MEDICARE AND PRIVATE SECTOR HEALTH CARE QUALITY MEASUREMENT, ASSURANCE, AND IMPROVEMENT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

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MEDICARE AND PRIVATE SECTOR HEALTH CARE QUALITY MEASUREMENT, ASSURANCE, AND IMPROVEMENT

TUESDAY, MARCH 21, 1995

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The Subcommittee met, pursuant to call, at 10 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
March 13, 1995
No. HL-5

CONTACT: (202) 225-3943

THOMAS ANNOUNCES HEARING ON MEDICARE AND PRIVATE SECTOR HEALTH CARE QUALITY MEASUREMENT, ASSURANCE, AND IMPROVEMENT

Congressman Bill Thomas (R-CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the subcommittee will hold a hearing on quality measurement, assurance, and improvement in the Medicare program and private sector health plans. **The hearing will take place on Tuesday, March 21, 1995, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.**

Oral testimony at this hearing will be heard from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Congress established the Medicare utilization and quality control peer review organization (PRO) program under the Tax Equity and Fiscal Responsibility Act of 1982, replacing the former professional standards review organizations. PROs are generally charged with reviewing services furnished to Medicare beneficiaries to determine if the services met professionally recognized standards of care and were medically necessary and delivered in the most appropriate setting.

In 1989, Congress established the Agency for Health Care Policy Research (AHCPR) to conduct and support research on the outcomes, effectiveness, and appropriateness of health care services and procedures. Congress specifically directed AHCPR to establish priorities for research reflecting the needs of the Medicare program, and a portion of AHCPR's authorized funding is supported by the Medicare trust funds. AHCPR's authorization expires at the end of fiscal year 1995.

In recent years, quality assurance efforts have moved toward development of accurate measures of quality that can be used to continuously improve care and assess the performance of health care providers and plans. In 1990, the Institute of Medicine issued Medicare: A Strategy for Quality Assurance, which, among other recommendations, called for a new focus in the Medicare program on the "collection, analysis, feedback, and dissemination of data and in the initiation of creative quality interventions."

In the private sector, the growing role of managed care has generated intense interest in establishing credible performance measures to allow employers and other purchasers to make informed health care decisions based on quality as well as cost.

In announcing the hearing, Chairman Thomas stated: "As we look for ways to increase health plan choices for beneficiaries, I am very interested in hearing from the experts how we can best assure professional, quality care as well as provide to the beneficiaries the information they need to make good health care decisions. I also look forward to hearing from the Administration about their on-going efforts, including the research agenda of the Agency for Health Care Policy and Research and its relationship to improving care for Medicare beneficiaries."

FOCUS OF THE HEARING:

The hearing will focus on exploring innovative quality measurement, assurance, and improvement systems that can be applied to the Medicare program, reviewing the effectiveness of current quality assurance programs for Medicare fee-for-service and Health Maintenance Organization beneficiaries, reviewing the activities of the AHCPR, specifically regarding outcomes research and its application to the quality improvement in the Medicare program, and assessing quality assurance and improvement initiatives in the private sector.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement, with their address and date of hearing noted, by the close of business, Tuesday, April 4, 1995, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are now available over the Internet at GOPHER.HOUSE.GOV, under 'HOUSE COMMITTEE INFORMATION'.

*****

Chairman THOMAS. The Subcommittee hearing will be in order. Welcome to the hearing regarding quality measurement, assurance and improvement in the Medicare Program and private sector health care plans. I consider the subject of today's hearing to be critical to the development of a successful approach to providing more health plan choices to Medicare beneficiaries.

To be more specific, the Congress and the administration, I believe, have an obligation to Medicare beneficiaries to assure that they get professional quality care. That applies to care providers through the fee-for-service system, as well as through health maintenance organizations and any other health plan arrangements. I also believe that we must go beyond that.

As we give beneficiaries more health plan choices, we must also give them information about the quality of care provided under those choices so that they can make good decisions for themselves.

As we all know, the private sector is leading a revolution in health care delivery as more Americans enroll in HMOs and other managed care arrangements. As purchasers have become more aggressive about controlling costs with managed care, they have also pushed for accurate, objective and consistent measures of quality. These measures would allow providers to better review their performance and continuously improve their care, while also giving purchasers the information they need to make informed decisions based on quality as well as costs.

I hope today's hearing will allow us to learn about private sector efforts to measure and improve quality and what this may mean for the Medicare Program. Let me mention that we have Dr. Phil Lee here today as one of the administration's witnesses along with Mr. Vladeck, who has been with us several times.

Some of my colleagues may not realize that the original authorization for the outcomes research agenda for the Agency for Health Care Policy and Research was initiated by Republican members of the Health Subcommittee, that is the former Ranking Member Bill Gradison of Ohio, whose picture I saw in the paper recently, and is funded in part by Medicare trust funds.

We did this to assure the research agenda had a focus on issues important to Medicare beneficiaries. I am anxious to hear from Dr. Lee about the Agency for Health Care Policy and Research agenda and how clearly it might help us improve care for Medicare beneficiaries. Also, I hope Mr. Vladeck's testimony on the Medicare peer review organizations will provide a useful baseline for our coming efforts to promote better quality measurement, which is, after all, the foundation for better quality care for Medicare beneficiaries.

I call on my colleague and Ranking Member from California, Mr. Stark, for an opening statement.

Mr. STARK. Thank you, Mr. Chairman. I thank you for scheduling this hearing to express your support for actions to protect and if possible to improve the quality of care which Medicare beneficiaries receive. There are several actions we can take to meet these goals. We can, first of all, avoid careless slashing of Medicare funding for purposes unrelated to the Medicare Program such as giving tax breaks to very wealthy seniors and other budget balancing gimmicks.

Second, we should work to prohibit those things we already know have a detrimental effect on quality, contracts with health plans which cherry pick and leave the sickest to fend for themselves, and therefore put undue burden on public hospitals, or contracts with health plans that are recklessly certified or poorly supervised by State governments largely because of a lack of Federal standards with which we can measure how well the State governments are indeed supervising these plans.

We ought to be very definitive about physician incentive payments in managed-care plans that end up turning them into Mary Kay cosmetic contests to see how doctors can withhold needed health services. It is difficult to measure the quality of a physician's service if the physician is told by some gatekeeper that he or she cannot provide the service to begin with.

Third, we should do whatever we can to enhance the state of the art of quality assurance through research. There is probably not now a method by which anyone would be willing to empirically judge the quality of a plan. It will take many more years of research and study to come up with guidelines with which we will be comfortable.

It is somewhat ironic we are holding this hearing when last week the Budget Committee suggested we should stop funding the Agency for Health Care Policy and Research, the very agency which might eventually help us come up with a system whereby we could achieve the Chair's goals.

The bottom line, Mr. Chairman, is if we are serious about protecting and improving the quality of health care in our country, we will require Federal action in a Federal program that now takes care of 35 million Americans, which is the finest health delivery system in the country today and that will require perhaps more Federal resources rather than less.

Philosophically, I know that is abhorrent to some people, but if we mean to protect the care of the elderly, we can't sacrifice it for tax cuts. We will have to be serious about paying for the quality we hope to receive. I look forward to hearing from the witnesses today.

Chairman THOMAS. I thank my friends in California. Let us here what the public is getting for its money. We will hear first Bruce Vladeck and then Dr. Lee. I would indicate to both of you that your entire written testimony will be placed in the record and you may proceed however you see fit to inform the Subcommittee and I will not turn the lights on, but if we can keep a reasonable structure, I am sure there will be questions. Thank you very much for being here.

STATEMENT OF HON. BRUCE C. VLADECK, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. VLADECK. Thank you, Mr. Chairman and Members. I am pleased to appear again before the Subcommittee and I am particularly pleased to be here this morning to discuss some of what the HCFA, Health Care Financing Administration, is doing to foster and assure the delivery of high quality health care to our

beneficiaries. It also is a special pleasure for me to share the witness table with Dr. Lee.

I hope at the conclusion of this hearing the Subcommittee will have a greater appreciation not only of HCFA's efforts at quality assurance, but also the collaboration between HCFA and the AHCPR, Agency for Health Care Policy and Research, on whom we rely very heavily for the building blocks of our quality efforts.

I will try to condense my statement as much as I can. Let me focus my remarks on changes we have been making to the Peer Review Organization, or PRO Program, and turn more specifically to quality assurance in managed care, which I know is of particular concern to this Subcommittee and to the Chairman.

Our mission is to guarantee health security to the beneficiaries we serve. In order to do that we must collaborate with providers, physicians, suppliers and managed-care plans to assure that services are of high quality and are appropriate. In fact, our approach to quality assurance includes a number of different pieces, including the development of health and safety standards for facilities, the survey and inspection of those facilities, and increasing efforts to educate our beneficiaries as to appropriate care, particularly to encourage them to receive preventive services.

We are engaged with the Agency for Health Care Policy and Research in studies on quality assessment and our increasing emphasis on, and concern with, program integrity activities also have major quality implications, because so often abuse of the programs involves abuse of the beneficiaries as well.

Let me talk first in more detail about the PROs. PROs are private entities, for-profit or nonprofit physician-governed organizations that work under contract to us to monitor and evaluate the care provided to Medicare beneficiaries. PROs have been in place in one form or another since 1972, but in the last three or 4 years we have undertaken a major transformation of their role and their activities.

In the past, PROs monitored quality mainly through intensive retrospective review of individual case records, whether physician charts or hospital charts, selected generally as part of a random sample. We have come to believe that that kind of look-behind case-by-case examination of individual clinical events for errors is less effective in improving the quality of care than is a more global and prospective approach.

By identifying patterns of care and outcomes across a larger sample of patients, we believe that providers can receive insights to systemic problems in how they are providing care. The best way to achieve high quality performance by providers in the long term is not to impose rigid standards from the outside nor to engage in an elaborate game of "gotcha", but rather to encourage them to maintain and strengthen their own internal quality management systems.

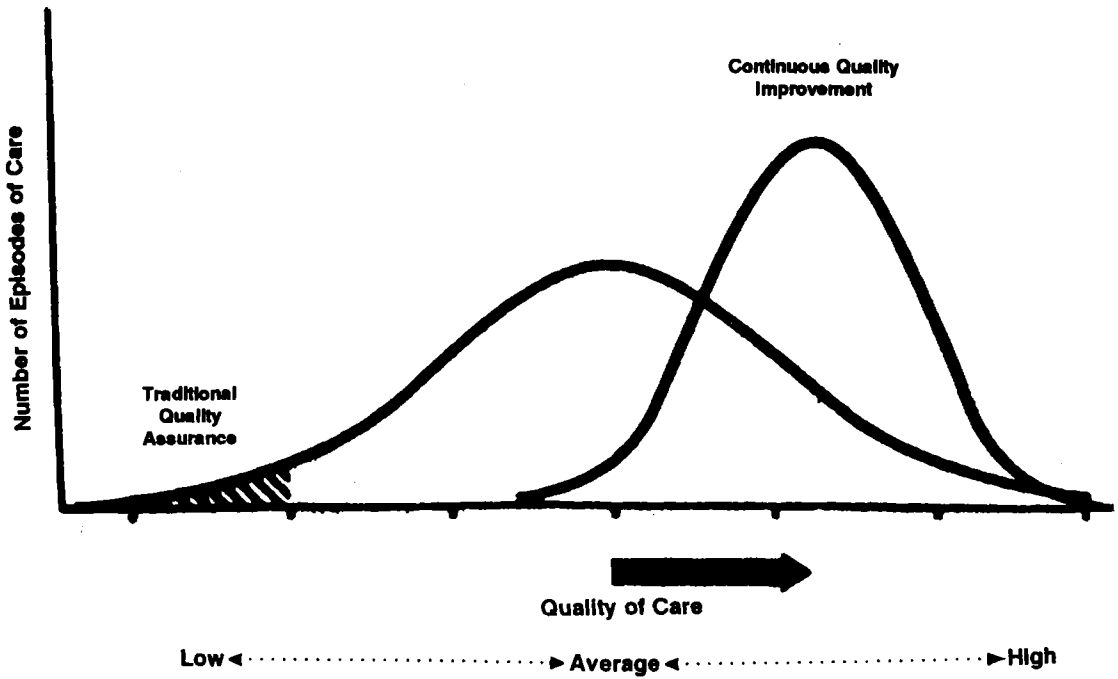
In taking this approach, we have borrowed freely from the best thinking in the private manufacturing and other corporate sectors in the revolution in industrial quality control and quality assurance that has occurred over the last couple of decades.

Perhaps I can best illustrate these concepts with a simple graphic representation. If one plots the quality of care of all health

episodes for all items of service or instances of service to Medicare beneficiaries, on a continuum from low quality on the left to high quality on the right, you get the typical distribution you see in all sorts of aspects of life.

[The following was subsequently received:]

IMPROVING THE MAINSTREAM OF CARE



What the PROs and old-style quality assurance efforts tended to do was to try to identify and focus on that very small left-hand tail of the distribution to catch the egregious cases on that end and then take some punitive action relative to them.

Increasingly, our philosophy is that the appropriate role of ours relative to quality—while not ignoring the problems in the left-hand tail—and the long-term payoff in terms of quality of services to our beneficiaries is to improve the level of quality of care in the program or in any provider by moving the distribution substantially in the direction of higher quality and by focusing more of it around professional norms or consensual levels of very high quality service.

We are less interested than we were in the past in detecting and punishing individual problems and more interested in increasing the standard of the norms of care and moving the general level of performance.

Continuous quality improvement aims to improve performance of all providers, not merely just those on the tail end, and it is done consistent with a philosophy of continuous quality improvement. There is no end point in this process. We hope to improve the quality of care continuously.

We have modernized the management of the PRO program under what we call our HCQIP, Health Care Quality Improvement Program, consistent with this philosophy. Under the HCQIP, we give providers, hospitals, or managed-care plans the tools to achieve internal continuous quality improvement while we can monitor on the basis of data about which there is a high degree of consensus improvements in quality.

Let me give you one example. One of our PROs looked at the claims from 53 hospitals in its State for Medicare patients with coronary artery disease who had undergone catheterization of the left heart and angiography procedures. They found that a number of those hospitals were routinely performing right heart catheterizations as well.

In many cases, the additional procedure was unnecessary and indeed involved some additional risk to the patient, although not an enormously large risk. Working with the hospitals and the State chapter of the American College of Cardiology, the PRO developed consensus criteria within the State for when right heart catheterization was appropriate and when it wasn't and shared those guidelines with providers.

Each of the hospitals then took that into their internal quality improvement processes and the result, within 6 months, was a very substantial reduction in the volume of unnecessary procedures of that sort. That is a prototype of the kinds of projects that PROs are undertaking around the country, some of them—as with the management of post heart attack patients—as part of national initiatives; many more of them in response to locally defined problems and priorities in identifying quality issues.

I want to assure members that the traditional statutory obligations of the PROs to continue to undertake retrospective case reviews in order to validate DRG classifications, to investigate beneficiary complaints, to assist in reviews of problematic providers referred to us from the Attorney General or to investigate alleged vio-

lations of antidumping regulations, have continued and will continue, and the authority of the PROs to impose sanctions in those instances is still in place and is still being used.

Again, I could give you, and would be happy to, a large number of other examples of the kind of work the PROs are doing, but I want to emphasize two things about our changes in the process. First, our management of the PRO program recognizes how heterogenous the health care system is and how different the problems of quality may be from one community to another.

There are differences in prevalence of disease patterns, there are differences in practice patterns, and there are differences in professional expectations. Our expectation of the PROs is that they work with the local physician and other professional communities, with consumer groups and others to identify problems of high priorities in their communities and then pursue them rather than following some national cookbook.

The other point to emphasize is how collaborative we insist this process is. The only way to ensure high quality care to our beneficiaries is to see to it that physicians and nurses and the other health professionals are providing high quality care. We do not ourselves administer injections or perform surgery and it requires a continuing and mutually collaborative partnership with the professional community in order to improve quality.

We are beginning to apply some of these same principles to our oversight of managed-care services. Even with the impatience some have suggested about the size of our managed care activities, we are, by far, the largest buyer of HMO services in the world. Slightly more than three million of our beneficiaries now receive their medical care through HMOs.

We require HMOs with whom we have risk contracts, the bulk of the plans which enroll our beneficiaries, to maintain internal and external quality review processes. We focus particularly on their capacity and the performance of the activities necessary to undertake internal quality assurance and quality improvement activities within the plan.

We also require the PROs to conduct external quality review in risk-contracting HMOs. Traditionally, the PROs' review of HMO patterns has been by the old model in which they looked at a sample of cases and tried to define deficiencies as well as following up on particular complaints and appeals.

We are in the process of transforming that to a system that will be consistent with the growing consensus about the appropriate way to do quality assurance and quality monitoring. It is essential that the system be accountable to consumers so that they can make informed choices, to providers so that they can do continuous quality improvement, and to the payers so they can make sure they are getting value for their money in protecting their beneficiary.

We are working on a number of initiatives in this regard. I need to emphasize, however, that the building blocks of any future system must rely on data on services provided by HMOs. Traditionally, many of the older group model and staff model HMOs did not maintain the level of data about the volume or content of services that we have come to expect in the fee-for-service sector and that are increasingly the backbone of our quality monitoring systems.

We believe that adequate quality assurance requires that managed-care plans collect data comparable to that maintained in the private sector relative to each patient encounter with a provider. We are going to work with the industry, with other large purchasers of care, toward the development of consensus about the content of standard data that need to be maintained by managed-care plans, need to be made available to purchasers, to quality monitors, and to others as the core of such a system.

We are working very closely with the NCQA, National Committee for Quality Assurance, to adopt their HEDIS system, a set of measures of planned performance to the particular needs and characteristics of the Medicare and Medicaid populations. We are somewhat further down the road on the Medicaid version for which we have already identified also sets of clinical indicators, most having to do with maternity services that are particularly important in the Medicaid population that haven't yet been a part of the HEDIS data set.

We are also working with the NCQA and other bodies, as well as the managed-care industry, to adopt the HEDIS, health plan employer data and information set, reports to the Medicare Program. At the same time, we are seeking to develop appropriate quality measurement tools and quality standards for managed care.

In 1993, we contracted with the Delmarva Foundation, which is the PRO for Maryland, and Harvard University to work with a panel of quality experts from around the country to develop new methods for external review based on outcomes measurement and quality improvement.

Dr. Heather Palmer, who is head of that project, is a witness on a subsequent panel and I will try not to step on any of her lines, but we are far down the road in developing mechanisms for analyzing data on core measures and for monitoring the performance of plans.

We are particularly excited about some of the measures for management of chronic diabetes, patients whose problems are precisely those that ought to be best addressed by effective managed-care plans and for whom episodic measures of quality care in either the fee-for-service or capitated sectors have probably been traditionally inadequate.

One of the things that managed-care plans have always pointed to with some pride was their substantially greater emphasis in, and investment in, preventive services and we are looking as part of this monitoring at the use of mammography and other standardized screening tests, and at management of hypertension as illustrations of the kinds of the services where one can measure the level of performance and assess the adequacy of care relative to some benchmarks of industry-wide or community-wide norms.

I would be overstating the issue, however, if I said that we were there, in terms of the development or implementation of these systems. We need continuous quality improvement in our quality assurance efforts just as much as any provider does. We are working in partnership with managed-care plans, with the States, with the medical communities, and with advocates to develop measures to gauge health plan performance whether the plan is a

capitated or fee-for-service plan, and the various pieces are all parts of a longer term strategy that will give us a set of measures of the performance of any plan and give that plan the tools with which to do continuous quality improvement within its own orbit.

Just to make sure that we are not all stepping on one another, next month we are sponsoring an invitational forum to bring together the wide range of public and private entities that are all developing systems for monitoring the quality of care delivered by managed-care entities and other health providers to make sure that we are talking to one another and not creating duplicative or contradictory systems—not to create any sort of monopoly situation, but to see that all of us with the same objectives are not getting in one another's way or imposing excessively burdensome requirements on the plans as part of our efforts to define measures of accountability.

We have a long way to go and I do not want to overstate how far we have gotten. The last point is our reliance on the AHCPR, as the most important objective source of outcome measures and professional consensus about appropriate standards for care on which we increasingly rely for the development and availability of standards around which to conduct these quality assurance and quality improvement activities.

The outcomes research done by AHCPR is a critical building block in our efforts. We have supported and continue to support the authorization of Medicare trust fund moneys to support the work of the agency because of our belief that that work is so integrally connected to the basic purposes for which the trust fund is available.

That gives me a segue to Dr. Lee and his comments on this and other issues, but I would be happy to answer any questions any of you might have. Thank you, again, for the opportunity to appear here today.

[The prepared statement follows:]

TESTIMONY OF BRUCE C. VLADECK, ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION

I am pleased to appear before the Subcommittee today to discuss the Health Care Financing Administration's (HCFA's) evolving role in fostering and assuring the delivery of high quality health care to over 36 million Medicare and 35 million Medicaid beneficiaries.

HCFA's mission -- as the nation's largest health insurer and a major purchaser of managed care services -- is to guarantee health care security to all the elderly, disabled, and disadvantaged populations we serve. Central to this mission is our commitment to collaborate with providers, physicians, suppliers, and managed care plans to assure that the services our beneficiaries receive are of high quality and appropriately meet their health needs.

As the largest payer for health care services in the country, HCFA also has a fiscal responsibility to all citizens to make sure that the dollars we spend are spent wisely. High quality care delivered in the appropriate setting is likely to be cost-effective.

HCFA's MULTI-FACETED APPROACH TO QUALITY ASSURANCE AND IMPROVEMENT

HCFA has reinvented and modernized its quality assurance and improvement activities under our Health Care Quality Improvement Program, or HCQIP. HCQIP gives providers, such as hospitals and plans, the tools to achieve internal continuous quality improvement; allows for the monitoring of how these plans and providers are achieving improved quality; and leads an effort in quality improvement projects throughout the country which allows us to improve care for large populations of patients. HCQIP was launched in April 1993, primarily through a re-engineering of our Peer Review Organization (PRO) contracts, but the program encompasses, or interfaces with, a variety of quality assurance and improvement activities.

Most of our quality assurance activities rely heavily on collaboration with our partners in the private sector and other organizations such as the PHS. Our innovations also strive to reduce unnecessary burdens on the industry.

- Quality assurance at HCFA begins with health and safety standards that form the nucleus of the requirements that all providers must meet to participate in our programs.

- Our survey and inspection activities, and those of private sector accrediting bodies, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), who have authority to accredit providers on our behalf, are designed to assure that Medicare and Medicaid-certified providers continue to meet the threshold participation standards of health and safety. Medicare conditions or participation require providers to have an internal quality assessment and improvement program.

- Beneficiary education is an important tool for improving quality. Over the past couple of years, we have embraced an ethic of customer service and beneficiary outreach. This effort includes a commitment to give beneficiaries a better understanding of what quality care is, educate them about their rights as patients to high quality care, and to disseminate reliable information about health plans to foster informed consumer choice.

- We fund empirical studies in state-of-the-art quality assessment, such as a recent grant to the RAND Corporation to develop a clinically-based method for assessing the quality of care delivered to women and children in managed care plans. The results of such studies are incorporated

into our quality monitoring activities.

- Various program integrity initiatives that seek to prevent, identify, and root out fraud and abuse also help improve quality. Fraudulent providers often provide poor quality or inappropriate care, which can be detrimental to beneficiaries' health and well-being.

- In quality monitoring, HCFA uses clinical practice guidelines (guidelines on appropriate medical practice), including those developed by the Agency for Health Care Policy and Research (AHCPR), as well as the private sector.

- Last but not least, we use the Peer Review Organization (PRO) program to monitor the quality of care provided in fee-for-service and managed care facilities. It is also through the Peer Review Program that HCFA sponsors innovative and cooperative improvement projects with partners in the health care community.

HCFA quality assurance activities are as equally prominent in the managed care area as they are in the fee-for-service sector of Medicare. Medicare is a major purchaser of managed care services, with estimated expenditures this year of about $13 billion for the provision of care to over 3 million enrollees, or about 10 percent of our beneficiaries. We are committed to improving the quality of care these beneficiaries receive.

I should note that we and managed care plans recognize we have much work ahead of us to develop reliable, effective, and efficient systems to assess quality in managed care plans. Fortunately, our experience with quality assurance outside of managed care provides us with a solid basis for developing the quality assurance mechanisms needed in the managed care environment. We are moving forward to improve quality in both fee-for-service and managed care with parallel objectives, although applications in managed care take some different forms.

As the Subcommittee has requested, I will focus my remarks on the innovations in the PRO program and then turn more specifically to quality assurance applications in the managed care arena, as this is an area of growing significance to Medicare and of particular interest to this Subcommittee.

THE PRO PROGRAM: A PARTNERSHIP WITH HCFA

We achieve our mission of assuring high quality services to our beneficiaries in partnership with members of the health care community. Nowhere is this cooperation and collaboration better exemplified than in the Peer Review Organization, or PRO, program, which operates in both the fee-for-service and managed care sectors of Medicare.

The PRO program has been in place in one form or another since 1972. While the structures for peer review have changed over the years, the goals of the program, as articulated by Congress, have remained essentially unchanged: to assure that services provided to beneficiaries are medically necessary, provided efficiently in the appropriate setting, and meet professionally recognized standards of care.

PROs are private entities that work under contract with HCFA. In general, a separate PRO operates in each State, although PRO activities are frequently carried out at an even more local level. PROs may be for-profit or non-profit organizations and are guided by boards of directors comprised of licensed clinicians, representatives from State medical societies, hospital associations and medical specialty societies, and consumer representatives. PROs employ physician advisors, epidemiological and statistical specialists, nurse reviewers, and

data technicians.

Innovations in the PRO Program

The Health Care Quality Improvement Program is leading to substantial innovations in the PRO program. In the past, PROs monitored quality mainly through intensive retrospective review of individual case records -- physician or hospital charts -- that were selected as part of a random sample. Upon identifying possible quality concerns, PROs have engaged providers in corrective actions; sanctions have been applied in cases of grossly substandard care or consistent poor quality.

We have come to believe that a look-behind, case-by-case examination of individual clinical events for errors is less effective in improving the quality of care than a more global and prospective approach that identifies patterns of care and health outcomes across a larger sample of patients. The case review approach does not give providers adequate insights into systemic problems in how they are providing care and does little to help guide providers toward fundamental improvements in care.

We have also recognized that the best way to achieve quality performance by providers in the long term is not by imposing rigid standards from the outside, but instead by encouraging providers to maintain and strengthen their own internal quality management systems. In this regard, HCFA has borrowed freely from the best thinking of the private sector, such as the manufacturing industry, which long ago embraced the doctrine of continuous quality improvement (CQI). The new approach we are implementing combines providers' internal quality management systems, driven by clinically-reliable data, with external monitoring and educational support from the PROs.

Quality Monitoring by PROs

Reliable data, which allow us to identify patterns of care, will obviously be at the core of quality monitoring. In the fee-for-service side of Medicare, we will use existing Medicare billing data and clinical data abstracted from medical records. (In collecting these data, HCFA and our contractors observe the same stringent protections for beneficiary confidentiality that have always characterized the PRO program.)

Quality indicators derived from improvement projects, which I will address momentarily, will assist PROs and providers in measuring and monitoring the quality of care provided to Medicare beneficiaries. Upon identifying aberrant patterns of care, PROs can then educate physicians about best practices and help hospitals develop internal monitoring systems that allow them to continuously improve the quality of care provided.

For example, one PRO examined claims from 53 hospitals of Medicare patients with coronary artery disease, who had undergone left heart catheterization and coronary angiography procedures. The PRO found that some hospitals routinely performed right heart catheterizations as well. For many of these cases, the additional procedure was unnecessary and could expose beneficiaries to risks and complications. Working with the hospitals and the State Chapter of the American College of Cardiology, the PRO developed consensus criteria for performing right heart catheterization and shared these guidelines with the providers. The hospitals engaged in various self-education efforts and our follow-up evaluation reveals a significant reduction in unnecessary right heart catheterization procedures.

While our new quality monitoring process will replace much of the traditional retrospective case review, I want to assure the Subcommittee that the PROs will continue to perform traditional retrospective case review, where appropriate, in order to meet

their statutory responsibilities to validate DRG classifications, and to investigate beneficiary complaints, alleged violations of anti-dumping regulations, and referrals from the Office of the Inspector General. Furthermore, the PROs and HCFA will still be responsible for imposing sanctions if education efforts fail.

Cooperative Quality Improvement Projects: Supporting the Goal of Improving Care

In addition to monitoring quality, PROs are also collaborating with providers, researchers, practitioners, and other groups in the health care community on projects that identify opportunities to improve the quality of care provided and allow providers to share lessons of best practices with others.

National and local quality improvement projects reflect our empirically-validated belief that opportunities are much greater to improve the overall health status of our beneficiaries on a broad scale by effecting modest improvements in many mainstream areas of care, rather than by focusing primarily on egregious errors through traditional case review. Projects may be developed by a single PRO, groups of PROs, or nationally.

To date, PROs have reported on hundreds of collaborative improvement projects, the results of which are shared throughout the country. We have received much positive feedback from providers and others in the industry about the value of these projects. HCFA and the PROs, working with providers, are catalysts for influencing the state-of-the-art of medical care so that all patients receive the best possible health care.

Improvement Project Examples

The prototype improvement project, launched in 1993, is the Cooperative Cardiovascular Project, which seeks to improve care for patients hospitalized with acute myocardial infarction, or a heart attack. HCFA developed quality indicators for care of heart attacks using guidelines developed by the American College of Cardiology and the American Heart Association. In pilot projects in Alabama, Connecticut, Iowa, and Wisconsin, the PROs found major opportunities to improve care for heart attack patients. In partnership with hospitals and their medical staffs, and with analytic support from AHCPR's Patient Outcomes Research Teams, we have derived state-of-the art measures of quality for heart attack hospitalizations and have identified best practices. Through the PROs, we are providing technical assistance to hospitals and will be monitoring the results. HCFA is now extending the cardiovascular project to the entire nation.

The project illustrates the major opportunities we have to improve care. Medicare beneficiaries have more than a quarter of a million heart attacks a year. If we can bring the level of care up to best practices, we should be able to save thousands of lives. While the traditional one-case-at-a-time approach was designed to identify egregious errors in care, quality improvement methods can have a much larger impact by effecting smaller changes in a large number of cases.

PROs have also embarked on numerous projects of a more local scope. For example, we are working to improve ambulatory care for patients with chronic disease in both fee-for-service and managed care environments. In the next six months, we will begin pilot projects in several States aimed at improving care for diabetics, using quality indicators based on guidelines from the American Diabetes Association and the Centers for Disease Control. We are also making extensive use of guidelines from the Agency for Health Care Policy and Research (AHCPR) to develop quality indicators for conditions such as unstable angina, prevention and treatment of pressure ulcers, and diagnosis and treatment of benign prostatic hypertrophy.

HCFA is proud of the quality monitoring and improvement innovations we have introduced in the PRO program. I want to re-emphasize three important points about our work in this area:

1. The PRO program consists of private organizations which, through a contractual arrangement with HCFA, monitor the quality of care furnished by providers. Quality monitoring and improvement relies heavily on collaborative efforts among HCFA, the PROs, providers, practitioners, experts, and others in the field.

2. The best way to achieve quality care in the long term is not by imposing rigid external standards on providers, but by encouraging and supporting internal continuous quality improvement activities. We strongly believe that the development and dissemination of clinical practice guidelines and best practices help hospitals render quality care.

3. Cooperative quality improvement projects give HCFA and its partners an opportunity to improve the overall health status of our beneficiaries on a broad scale. These projects have received a warm reception by the industry.

QUALITY ASSURANCE AND IMPROVEMENT IN MANAGED CARE

In 1994, Medicare managed care plan enrollment increased by 16 percent. At present, about ten percent of our beneficiaries have chosen to enroll in HMOs. Based on this recent experience, as well as advances in the marketplace, we anticipate continued, substantial growth in our managed care caseload, even absent changes in current law. We are keenly interested in assuring that as the Medicare managed care program grows and evolves, we have adequate measures in place to assure and improve the quality of the care they provide.

Designing these measures is a challenge, as we must broaden our focus from facility-based care to the activities of an entire network of providers -- including physicians' offices. Further, unlike fee-for-service medicine, where each medical encounter results in a claim, information about particular services provided by managed care organizations is limited. We are facing up to this challenge and working closely with the managed care industry to develop appropriate and meaningful procedures that can be relied on by HCFA, by our beneficiaries, and by the managed care plans.

Internal Quality Assurance Programs

Parallel to the fee-for-service sector, quality of care in managed care systems can be divided into (1) internal mechanisms, that is, each plan's own internal structure and activities for continuous improvement, and (2) external measurements, that is, performance measures imposed by external entities, for example, purchasers. Currently, Medicare risk HMOs must meet requirements for both internal and external quality review. In addition, we are exploring ways to improve external review programs, in partnership with managed care plans, commercial purchasers, and other interested parties and to maintain currency with state-of-the-art internal improvement processes.

With respect to internal structures, the Medicare statute and regulations require all contracting plans to have an internal quality assessment and improvement program, which involves the following:

- an ongoing program with a written plan describing the structure, responsibilities, types of activities, and specific quality improvement projects for the coming year; a committee of practicing physicians and other

representative practitioners with the commitment of adequate resources, including systems and staff; and Board accountability for the program;

- an approach and activities stressing health outcomes which cover the entire range of care provided, and looks at the effects of provider compensation and incentives arrangements to assure that appropriate services are in fact provided;

- a systematic, iterative process to identify problems and areas for improvement, make appropriate changes; and monitor changes over time for effectiveness;

- peer review by physicians and other health professionals of the process of clinical care;

- systematic data collection of performance and patient outcomes, and interpretation and feedback of these data to practitioners; and

- written procedures for taking appropriate actions to change areas needing improvement, and a process to determine the overall effectiveness of the program and individual action plans.

HCFA does not do business with managed care organizations unless they have these internal quality assessment and improvement programs in place prior to contracting; we follow-up with on-site reviews of our contractors every two years thereafter. In evaluating an HMO's quality assessment and improvement program, staff review the written plan and the resultant activities, and look for changes and improvements in the delivery of quality medical care. Further, HCFA looks at the involvement of a plan's Board and top management in assessing the effectiveness of ongoing activities, specific actions and the overall program.

HCFA's enforcement authority is broad, from halting enrollment and marketing of non-compliant plans, to intermediate sanctions, to revocation of Federal Qualification and contracts with Medicare. Currently HCFA has three corrective actions underway with contractors, with a fourth investigation in progress, all of which are the result of quality of care deficiencies.

External Quality Assurance Programs

At this time, the PROs conduct HCFA's external quality assurance activities in Medicare risk-contracting HMOs. Since 1987, PRO review has consisted of review of (1) a sample of patient records, (2) a sample of Medicare enrollee deaths, and (3) all complaints PROs receive from Medicare HMO enrollees. If a pattern of quality problems is identified, an action plan is developed by the managed care plan in concert with the PRO. The PRO then monitors performance under the plan to ensure that the necessary improvements have been implemented.

However, HCFA, the PROs, and managed care plans believe that external review of HMOs must evolve into a uniform performance measurement system, rooted in a single set of measures that gauge a health plan's responsiveness to the needs of its membership. This represents a substantial undertaking, and entails a long-term effort we must begin now if we are to attain a seamless data and performance measurement system for quality care for all patients in all plans. HCFA, as the nation's largest managed care purchaser, must be the catalyst for this effort. Such a data system will bring accountability:

- for consumers, who will have the information they need to make informed, responsible choices;

- for providers, who will have the figures they need for continuous quality improvement and sensitivity;

- and for plans, which will have the numbers to target resources and respond to the needs of diverse populations in Medicare and Medicaid.

The Oregon Scorecard Project, supported by AHCPR, should be helpful as we seek to develop meaningful quality indicators that beneficiaries can understand and use to make good choices regarding their health care.

Encounter Data

The building blocks of any future performance reporting system must be data on services provided by HMOs. While such data are readily available in the fee-for-service sector as a by-product of payment, many managed care plans do not currently have encounter data available due to the nature of prepayment. HCFA believes that adequate quality assurance activities require that managed care plans collect comparable data reflecting the key content of each patient encounter with a managed care provider. With comprehensive and comparable data, plans would be able to provide reports to purchasers addressing a range of purchaser needs.

HCFA is currently working in partnership with the managed care industry, States, and others in several important efforts to define encounter data standards for managed care plans. As the nation's largest managed care purchaser, we demand accountability and continuously improving outcomes from our contractors, just as any private purchaser would require. We recognize that plan collection of encounter data will, in many cases, be burdensome. However, without plan collection of encounter data, a quality improvement reporting system cannot be attained. As this will be a long-term undertaking, HCFA is making every effort to minimize the requirements we place on managed care plans for reports derived from this data. This is exemplified by one of our most exciting initiatives, our partnership with the industry on the Health Plan Employers Data and Information Set, or HEDIS.

Medicaid and Medicare HEDIS

With the rapid increase in the numbers of enrollees in managed care in the commercial sector, plans and employers began working together to develop a new HMO performance measurement tool. HEDIS is a core set of measures designed to help private sector firms gauge the value of the services provided by the firm's health plans. HEDIS includes data on a specified set of quality measures as well as measures of beneficiary satisfaction, financial indicators, and access to care. It is continually revised, with the third version expected next year. It will eventually permit consumers to compare the quality, value, and other merits of competing health plans. HCFA is now working to adapt HEDIS to the Medicare and Medicaid populations.

We are working jointly with the originator of HEDIS, the National Committee for Quality Assurance (NCQA), and with State Medicaid directors, consumers, provider groups, the United States Public Health Service, and the managed care industry on a Medicaid version of HEDIS. HCFA's goal is to adapt this promising commercial sector reporting tool to the needs of the Medicaid program and its beneficiaries. The Medicaid HEDIS project is funded by the David and Lucille Packard Foundation.

The Medicaid HEDIS project has twin objectives:

- First, by the end of 1995, produce a Medicaid-specific performance measurement set that we can provide to State Medicaid programs.

- Second, introduce Medicaid-relevant measures into the next version of HEDIS, version 3.0.

HCFA chose to use HEDIS as the template for our Medicaid effort because the managed care industry has used it for several years, and because the first step toward coordinated, quality care is uniform, consistent data. Furthermore, using HEDIS for Medicaid will build upon an established effective reporting system used by many large employers, while minimizing reporting burdens on our managed care plans.

While still on the drawing boards, HCFA also is designing a "Medicare HEDIS," with the support of the Kaiser Family Foundation. At present, HEDIS specifically excludes HMO enrollees who are age 65 or older. HCFA is working with the NCQA and others to develop a variety of measures for the Medicare population that will be incorporated into a future version of HEDIS. Medicare HEDIS will provide HCFA with a much broader array of vital and actionable information on health plan quality and value, and represents the template for our quality and performance measurement efforts.

The Delmarva Project

In 1993, HCFA contracted with the Delmarva Foundation (the PRO for Maryland) and Harvard University to work with a panel of quality assurance experts to develop a new methodology for external review. The Delmarva contract was intended to help HCFA and the PROs shift from the current mode of HMO oversight to one based on outcomes measurement and improving the quality of care. This project runs parallel to, and contributes to, our Medicare HEDIS effort.

Delmarva's report, released in August 1994, recommended three core performance measures that would apply to all Medicare enrollees in the HMO. The core measures included access to services, an annual influenza vaccination, and screening mammography for women.

We will pilot test some of the recommendations made by Delmarva within the coming months. The pilot will involve several PROs and their HMOs and will test mechanisms for analyzing data on the three core measures as well as measures developed for treatment of diabetes. Using this information, the participants will work cooperatively to develop projects to improve quality of care based on this analysis.

Along with information derived from a similar project underway in the fee-for-service sector (the Ambulatory Care Quality Improvement Project), HCFA expects to learn much about using performance measures to improve the quality of care for beneficiaries with diabetes. The lessons in outcomes measurement we will learn from projects like Delmarva, in combination with the results of our HEDIS efforts, will move us and the managed care industry down the road toward the uniform performance reporting system we all seek.

Coordination Activities

As I stated earlier, our performance measurement goals entail a long-term effort. Our over-arching goal is to work in partnership with the managed care industry, the states, the medical community and advocates alike to develop a single set of measures that gauge a health plan's performance. Our work on encounter data as the building blocks, HEDIS as the reporting template, and on Delmarva as a first attempt at examining compliance with performance measures, are early steps down the road to a performance measurement system that will enable managed care plans to continuously improve their quality of care and empower consumers to make responsible, informed choices.

As an example of this new partnership, HCFA is sponsoring an invitational forum to challenge both public and private entities to address the need for coordinated monitoring of managed care entities and other health care providers, to be held on April 19. We have invited stakeholders in this important industry; these include representatives of HCFA and the Public Health Service (PHS) involved as payers and regulators of managed care, State departments of health, insurance and Medicaid, HMOs, the managed care industry trade associations, accrediting organizations, employer associations, physician organizations involved in quality improvement, and consumers.

CONCLUSION

There are many exciting initiatives in the field of measuring quality of care in the fee-for-service sector and in managed care plans. We know that the activities described here will be refined, improved and modified as we work with our partners in the private sector to advance the state of the art in assessing quality of care. This is an exciting endeavor whose main purpose is to improve the well-being of beneficiaries through continuous quality improvement. This effort, supported by employers, plans, providers, and beneficiaries, still has a long way to go. We look forward to continued progress in this area, and hope to have the Subcommittee's support.

Finally, I would like to encourage the Subcommittee to support continuing the authorization of AHCPR to use Medicare trust fund monies for outcomes research. AHCPR's outcomes research program is a critical building block to HCFA's quality measurement and control activities. I will defer to Dr. Phil Lee, Assistant Secretary for Health at the Department of Health and Human Services, for further comments on this matter.

I would be happy to answer any questions

Chairman THOMAS. Thank you, Bruce. I would like to have Dr. Lee testify before questions. It is my pleasure to welcome Dr. Phil Lee, who is the Assistant Secretary for Health, United States Department of Health and Human Services, to talk about HHS' effort to ensure quality of health care with some emphasis and examination of the AHCPR.

STATEMENT OF HON. PHILIP R. LEE, M.D., ASSISTANT SECRETARY FOR HEALTH, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. LEE. Mr. Chairman, thank you very much. Members of the Subcommittee, it is a pleasure to be here and particularly to be here with Dr. Vladeck. I will be discussing the role of the Public Health Service and the many important ways in which we collaborate with HCFA on joint efforts to ensure the quality of health care provided Medicare and Medicaid beneficiaries.

All the agencies of the Public Health Service are involved in quality activities of one sort or another. I want to focus this discussion on the AHCPR because of our role with the Health Care Financing Administration and the specific authorizations provided under the leadership of this Committee.

Health services research, which is the principal mission of the AHCPR, begins where biomedical research ends. It focuses on questions at two levels, the individuals and the organization and financial arrangements through which care is provided to populations. The goal is to improve the quality, appropriateness and effectiveness of health care services, as well as access to such services.

The agency accomplishes its mission through a broad-based program of health care systems and medical effectiveness research, development of clinical practice guidelines, technology assessment and quality measurement and improvement activities. Congress authorized the AHCPR 5 years ago as the Federal focal point for health services research, especially in the area of quality improvement.

Quality measures are even more important in today's rapidly changing health care marketplace with its growing emphasis on managed-care delivery systems, accountability and value-based purchasing for medical benefits. This is particularly true for Medicare, as increasing numbers of beneficiaries are turning to managed-care plans for care.

Consistent with the intent of Section 1142 of the Social Security Act, the needs and priorities of the Medicare Program are reflected in the AHCPR supported activities. Support under this authorization comes from Medicare trust funds and appropriated funds. The agency focuses on what works and what does not work in real world health care settings. It does this by systematically documenting current practices and examining their effectiveness, developing better measures of quality, and generating information that informs decisionmakers at all levels of the system.

At the individual or patient level, the AHCPR provides valuable information to help consumers make informed decisions about which treatments are best for them. For the buyers of health care such as large corporations, information generated by the agency

helps them evaluate which health care plans offer the highest quality of care at the lowest cost.

At the level of the clinician, the agency's research and guidelines help to improve practitioner decisions by providing information about effective medical treatment and the outcomes of that treatment. For insurers and managed-care plans, the Agency for HCPR sponsors research and guidelines to provide a more rational basis for decisions about treatments and technologies that are most effective and how quality can be achieved. Many important findings have emerged from the agency-supported research that illustrate the value of the AHCPR's work to HCFA programs and particularly to the Medicare beneficiaries.

The patient outcomes research teams, or so-called PORTs of prostate disease focused on transurethral resection of the prostate. Those are called TURPs. It is one of the most common surgical procedures paid for by Medicare. The PORT questioned the effectiveness of this procedure and noted the frequent occurrence of complications, including incontinence and impotence.

As physicians learned more about these findings and as patients learned more about treatment options from their physicians, practice patterns began to change. Now, the majority of men who are fully informed about the potential outcomes of this surgery elect not to have it or to delay it until symptoms become more severe.

Recently, there has been a 30-percent decline in the number of surgeries performed for benign prostatic disease, reflecting the application of this research very broadly through medical practice. This decline is associated with significant cost savings, while at the same time reflecting more effective care that is consistent with patient preference.

Another area of success involves cataract surgery. Over the last 3 years, cataract surgery has declined 7 percent due in part to the findings of the cataract PORT and the Agency for Policy and Research cataract guidelines. The agency's studies helped shift decisions about cataract surgery to the impact of the cataracts on patient functioning and not just on the existence of a cataract.

The Agency has undertaken another study of potential benefit to practitioners, Medicare beneficiaries and the taxpayers in its funding of a large trial to determine whether or not routine medical tests prior to cataract surgery costing $150 million a year are of benefit and are cost-effective. This is a large relatively simple trial.

The agency-supported PORTs have also contributed to the development of HCFA's cooperative cardiovascular project. The project will promote improvements in care by collecting data on patterns of care and outcomes for selected cardiovascular conditions and provide analyses to hospitals and their medical staffs.

These examples have significant relevance for the Medicare Program. If one examines the topics of all AHCPR-supported PORTs and clinical practice guidelines, collectively they address 10 of the 15 most costly diagnosis for which Medicare patients are hospitalized. This represents about 80 percent of the amount billed by hospitals to the Medicare Program.

What about the future? I think recent AHCPR initiatives underscore areas of future progress. The recent agency initiatives

in two areas hold promise for even more progress. First, in the area of outcomes research leading to more definitive information on medical effectiveness; and second through development and testing of clinical quality measures and consumer information to document poor versus good quality and to facilitate the continuous improvement of care overall. Bruce mentioned that in the chart he displayed.

Among the agency's new projects addressing the senior population is a collaborative effort with NIH, the hypertensive lipid lowering heart attack trial. This trial will compare several different medications for control of hypertension and high cholesterol in an effort to improve prevention of heart attacks.

Another PORT project will focus on the treatment of localized breast cancer in elderly women. In an effort to close the loop between availability of information about medical effectiveness and its application in everyday practice, the AHCPR is developing methods for evaluating the performance of health care providers and practitioners. This quality measurement and improvement initiative involves several activities I would like to highlight.

The AMRRC, American Medical Review Research Center, is developing quality utilization review criteria and performance measurement tools based on agency-supported clinical practice guidelines for urinary incontinence, acute postoperative pain, and benign prostatic hyperplasia.

This project involves five Medicare PROs in Massachusetts, Michigan, Pennsylvania, Alabama and Maryland. Work on acute pain guidelines has shown that compliance with the guidelines can reduce costs as well as improve quality of care provided Medicare patients.

In another area, PROs are working independently to incorporate recommendations from the agency-supported clinical practice guidelines into their Medicare review activities. For example, a patient complained that an HMO had denied cataract surgery, which caused a Florida PRO to initiate a statewide quality improvement project.

As a result of this project, three Medicare HMOs changed their surgical criteria to conform with the AHCPR supported guidelines. HCFA and the Connecticut PRO are collaborating to incorporate practice guidelines into the Medicare quality indicator system.

Preliminary analysis from chart reviews for pressure ulcers have shown significant opportunities for quality improvement. Several Agency for Health Care Policy and Research Projects place special emphasis on quality using managed-care settings.

Another area of agency work is in developing accepted criteria for evaluating the validity or usefulness of clinical quality measures which currently do not adjust for special populations or for levels of risk. For example, if a hospital or health plan has a low incidence of low birth babies, is that an indication of the organization's strength in the area of prenatal care or does it mean that it does not reach and treat high risk populations? For these reasons, the agency has undertaken a joint project to identify and describe existing clinical performance measures.

Let me say a word about improving consumer choice. Today's patients are too often faced with difficult choices and too little

information. First, they must decide whether to purchase health care coverage; second, to make a choice that must rely too often on inadequate information.

The patient and their family is frequently left unable to evaluate the quality of the plan or the value of its providers. To assist in filling that void, the AHCPR has undertaken an effort to determine consumer attitudes about the accessibility, quality and effectiveness of the care they receive as well as their satisfaction with that care.

A unique feature of this project is it is being designed to reach a variety of consumer groups, including heavy users of health care, Medicaid recipients and others who might have difficulty negotiating the system. The initial development phase is completed and field testing will begin shortly.

Let me close by noting that the authority for the AHCPR under the Social Security Act needs to be renewed. I believe the evidence is clear that Medicare beneficiaries have been well served by the research and guidelines that the AHCPR has undertaken, but more must be done.

If we are to continue to improve the quality of care for Medicare beneficiaries and other patients, more research is essential. We will continue to work closely with HCFA, physicians, hospitals, health plans, researchers, and consumers to achieve this objective. We look forward to working with the Members of this Committee as well as we seek the reauthorization for these provisions for an additional 5 years. I would be pleased to join with Bruce in answering any questions.

[The prepared statement follows:]

TESTIMONY OF PHILIP R. LEE, M.D.
ASSISTANT SECRETARY FOR HEALTH
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good morning, Mr. Chairman and Members of the Subcommittee. I am very pleased to have this opportunity to speak with you today about the role of the Public Health Service (PHS) and the many important ways in which we collaborate with the Health Care Financing Administration (HCFA) in joint efforts to assure the quality of health care provided to Medicare and Medicaid beneficiaries.

There are four main points I want to leave with you today:

First, all elements of the Public Health Service are committed to improving the quality of care provided to all Americans. In many instances improving quality also saves money.

Second, we need a firmer science base and better tools to learn what aspects of health care can be improved and how to accomplish that.

Third, we have a special obligation to consumers -- to listen to their concerns and help them make better choices about their personal health and health care services.

And finally, we are committed to continuing our collaboration with the Health Care Financing Administration in its pursuit of high quality care for its beneficiary populations.

PHS Perspective

The perspective of the Public Health Service with respect to quality assurance and improvement is very broad -- taking into consideration not only personal health care services and their outcomes, but also environmental influences, preventive services, and more traditional public health functions. My goal of reinventing public health is grounded on three strategies:

1) focusing the personal health care system, making it a more active, accountable, and cost-effective participant in achieving health objectives;

2) redefining the public health system to strengthen its capacity to deliver population-based health services and to foster better collaboration with other sectors involved in health; and,

3) strengthening the capability of all sectors to address high priority health problems through support for training, research, and information systems.

In other words, we want to make health matter for all participants of the health care system by supporting and rewarding them for working individually and together to protect and improve the population's health.

Quality is and must remain a driving force for reinventing public health and improving the health care system. This is of particular importance to the Medicare program as an increasing number of beneficiaries move into managed care plans.

Many PHS programs and activities directly address quality measurement and improvement. For example, the National Institutes of Health (NIH) supports basic and clinical biomedical and behavioral science research which answers questions about what causes diseases and how diseases can be prevented and treated. Over the past 2 years, for example, NIH has funded research that reduced heart attacks for post menopausal women through estrogen replacement therapy. NIH has also funded research that has led to advances in the treatment of sickle cell anemia, congestive heart failure, and type I diabetes mellitus.

National Practitioner Data Bank
Another PHS program aimed at improving the quality of services provided to Medicare beneficiaries is the National Practitioner Data Bank. Authorized by the Health Care Quality Improvement Act of 1986, the Data Bank was established to encourage greater efforts in professional peer review and to restrict the ability of incompetent practitioners to move from State to State without discovery of previous substandard professional performance or unprofessional conduct. Certain information such as malpractice settlements, licensure restrictions, etc., is required to be reported to the Data Bank. Hospitals are required to regularly query the Data Bank before granting staff privileges.

Community and Migrant Health Centers.
Many Medicare beneficiaries are served by Community and Migrant Health Centers, another program of the Public Health Service. The quality of care is a very important component of the Community and Migrant Health Center program. Each center must conform to an established set of "Program Expectations", and periodically is subjected to an intensive, three-day on-site "Primary Care Effectiveness Review" in which clinical performance is carefully assessed, with follow-up technical assistance rendered when needed. In addition, the Community and Migrant Health Centers program has developed specific "clinical performance measures", including one targeted exclusively on geriatric care.

Substance Abuse and Mental Health Services
SAMHSA assists States, professional organizations and other groups in program improvement in the area of alcohol, drug abuse, and mental health (ADM) services by bridging the gap between researchers and providers. SAMHSA serves as the conduit for technology transfer to assist service providers in the delivery of safe, appropriate and effective prevention and treatment services. In addition, SAMHSA listens to consumers and their advocates to improve current practices and assess their effectiveness.

SAMHSA's National Advisory Council has strongly supported efforts around quality assurance and ADM services. The Council has passed several resolutions encouraging the development of a single set of national quality of care standards for ADM services and SAMHSA, with Council support, is now in the process of initiating a project designed to develop managed care network accreditation and quality assurance standards.

The many efforts that focus on issues of health outcomes and quality cut across HHS agencies. For example, PHS agencies, including the National Cancer Institute at NIH, the Centers for Disease Control and Prevention, the Food and Drug Administration, the Agency for Health Care Policy and Research, and the Office on Women's Health in my immediate office are assisting HCFA in its campaign to encourage Medicare enrollees to obtain mammograms. This represents the best possible kind of cooperation between our two agencies.

AHCPR - Principal PHS Quality Agency

Within the Public Health Service, the Agency for Health Care Policy and Research's (AHCPR) primary mission is quality measurement and improvement. AHCPR focuses on what works and what doesn't work in real world health care settings -- it has as one of its highest goals to assure that Americans can receive high quality care [in return for the one trillion dollars spent annually on health services]. It does this by systemically documenting current practices and examining their effectiveness, developing better measures of quality, and

generating information that informs decision-makers at all levels of our system.

At the individual or patient level, AHCPR provides valuable information to help consumers make informed decisions about which treatments are best for them. For the buyers of health care, such as large corporations, information generated by AHCPR research helps them evaluate which health care plans offer the highest quality care at the lowest cost.

At the level of the clinician, AHCPR's research and guidelines help to improve practitioner decisions by providing information about effective medical treatment.

For insurers and managed care plans, AHCPR-sponsored research and guidelines have enormous potential to provide a more rational basis for decisions about which treatments and technologies are most effective, and how quality can be achieved. Examples include surgical procedures for cataract and prostate disease, which I will discuss later.

AHCPR's Mandate

The Congress authorized AHCPR five years ago as the Federal focal point for health services research, especially in the area of quality improvement. With strong bipartisan support, consensus was reached on the need for research and development on issues of medical effectiveness and the delivery of health services. It further reflected the need to create a single focus independent of the programmatic or regulatory needs of specific governmental programs. This Subcommittee was a participant in that process.

The Subcommittee recognized the importance of health services research and its critical role in forming the knowledge base for the development of quality measures and quality improvement strategies -- the topic of today's hearing. Quality measures are even more important in today's rapidly changing health care marketplace with its growing emphasis on managed care delivery systems, accountability, and value-based purchasing for medical benefits.

Health services research begins where biomedical research ends. It focuses on questions at two levels: the individual; and the organizational and financial arrangements through which care is provided to populations. The goal is to improve the quality, appropriateness, and effectiveness of health care services, as well as access to such services.

AHCPR accomplishes its mission through a broad-based program of health care systems and medical effectiveness research, development of clinical practice guidelines, technology assessments, and quality measurement and improvement activities.

Consistent with the intent of section 1142 of the Social Security Act, the needs and priorities of the Medicare program are reflected in AHCPR-supported guidelines and other research activities. Support under this authorization comes from both Medicare trust funds and appropriated money.

Contributions of AHCPR

Many important findings have emerged from AHCPR-supported research over the last 5 years that illustrate the value of AHCPR's work to HCFA programs and the health care system in general.

For example, under direction of John Wennberg at Dartmouth College, AHCPR's Patient Outcomes Research Team (PORT) on

prostate disease focused on transurethral resections of the prostate (TURPs), one of the most common surgical procedures paid for by Medicare. The PORT questioned the effectiveness of this procedure and noted the frequent occurrence of complications, including incontinence and impotence. As physicians learned more about these findings, and as patients learned more about treatment options, practice patterns began to change. Now, the majority of men who are fully informed about the potential outcomes of this surgery elect not to have it. Recently, and despite the increased number of Medicare beneficiaries who would be candidates, there has been a significant decline in the number of surgeries performed for benign prostatic disease. More specifically, over the past 3 years, the number of TURPs has declined by over 30 percent. This decline is associated with significant cost savings, while at the same time reflecting more effective care that is consistent with patient preferences.

Cataract surgery has been the most commonly performed surgical procedure covered by Medicare, accounting for over $3 billion in 1991. Its use has declined 7 percent over the last 3 years, due in part to the findings of the cataract PORT and AHCPR's cataract guideline. AHCPR's studies helped shift decisions about cataract surgery to the impact of the cataract on patients' functioning, and not just on the existence of a cataract. The PORT developed a new tool for assessing the impact of cataracts on a person's vision and ability to perform usual activities. The measure (the "VF-14") has been widely accepted by ophthalmologists as an indicator of whether or not a particular patient will benefit from having a cataract removed.

The cataract PORT documented marked variation in the extent of preoperative medical laboratory tests ordered for cataract patients, physicians' reasons for ordering them, and much uncertainty about their clinical utility and cost effectiveness. Nonetheless, routine performance of medical laboratory testing prior to cataract surgery accounts for annual costs of approximately $150 million.

These findings lead to the funding of a "large, simple trial," in which 20,000 cataract surgery patients will be randomized to receive or not receive a routine battery of preoperative laboratory tests. Analyses will determine the health benefits and cost-effectiveness of routine laboratory testing for cataract surgery.

AHCPR-supported PORTs have also contributed to the development of HCFA's Cooperative Cardiovascular Project (CCP) that Bruce Vladek mentioned earlier. The CCP will collect data on patterns of care and outcomes for selected cardiovascular conditions and provide analyses, based on these data, to hospitals and their medical staffs to promote improvements in care. Investigators from AHCPR's PORTs on ischemic heart disease and acute myocardial infarction (AMI) assisted HCFA in designing the project and will provide special support in data collection, analysis, and dissemination strategies.

In addition, a separate grant supported by AHCPR will validate national guidelines for AMI patients for angiography, coronary artery bypass graft (CABG), and percutaneous transluminal angioplasty (PTCA). Acute myocardial infarction is the leading cause of death in the U.S. In 1993, approximately 600,000 Americans were hospitalized for it at a cost of tens of billions of dollars in additional health care costs and lost productivity. In cooperation with HCFA and the CCP, the project will examine the multiple factors associated with processes of care, their relationship to guidelines, and subsequent patient outcomes. Guidelines created from a cost-

effectiveness perspective will be compared with those created primarily from a clinical perspective.

All three of the examples of PORT research I've presented have special relevance for the Medicare program. If one examines the topics of all AHCPR-supported PORTs and clinical practice guidelines, collectively they address 10 of the 15 most costly diagnoses for which Medicare patients are hospitalized, representing about 80 percent of the amount billed by hospitals to the Medicare program. Similarly, these efforts address 9 of the 15 most costly diagnoses for which Medicaid patients are hospitalized, representing about 70 percent of the amount billed to the Medicaid program.

Ongoing and Planned AHCPR Initiatives

Clearly, much has been learned from AHCPR's initial 5 years working toward improved quality of care provided to all Americans and enhanced ability of consumers and purchasers, including HCFA, to monitor performance and select among competing health care plans and providers. Recent AHCPR initiatives in two areas hold promise for even more progress: first, in the area of outcomes research leading to more definitive information on medical effectiveness; and second, through the development and testing of clinical quality measures and consumer information to document poor vs. good quality and to facilitate the continuous improvement of care overall.

Among AHCPR's new projects addressing the senior population is a collaborative effort with NIH to support a large clinical trial, known as the ALLHAT Study (Antihypertensive, Lipid Lowering, Heart Attack Trial). This trial will compare several different medications for control of hypertension and high cholesterol; the goal is improved prevention of heart attacks. Patients will be enrolled from over 200 community-based practices and clinics, including primary care practice networks. The minimum age for enrollment is 60, and at least 50 percent of enrolled patients will be African American. The NIH portion of the study will assess side effects of medications and estimate patient compliance. To broaden the range of outcomes examined, the AHCPR is supporting a companion study to examine the quality of life associated with the various medications and their cost-effectiveness.

A new PORT project focuses on the treatment of localized breast cancer in elderly women. In 1990 an NIH Consensus Panel recommended that breast conserving surgery (BCS) accompanied by lymph node dissection and radiation therapy should be the preferred treatment for most cases of localized breast cancer. Despite these recommendations, the use of breast conserving therapy in women aged 65 and older varies considerably. This project will examine treatment choice, short and intermediate-term outcomes, and cost-effectiveness of three alternative treatments for localized breast cancer in the elderly. Recommendations will be developed regarding the appropriateness of observed patterns of treatment, taking account of circumstances that may differ with patients' age, initial health, and access to different types of providers.

Another new AHCPR initiative will help to close the loop between the availability of information about medical effectiveness and its application in everyday practice. One part of this initiative involves the development of valid and useable measures of the quality of care -- in essence, translating the conclusions from outcomes research, clinical practice guidelines, and technology assessments into quality measures that are easy to apply and understandable by both health professionals and consumers. Another part of this initiative involves the development of sound and credible

methods for evaluating and improving the performance of health care providers and practitioners. The existence of quality measures and information about levels of quality is of limited value unless it is coupled with strategies for quality improvement. Let me share with you just a few of the activities that are already part of this quality measurement and improvement initiative.

The American Medical Review Research Center is developing quality and utilization review criteria and performance measurement tools based on three AHCPR-supported clinical practice guidelines (for urinary incontinence, acute postoperative pain, and benign prostatic hyperplasia or BPH). The project utilizes five Medicare Peer Review Organizations (PROs from Massachusetts, Michigan, Pennsylvania, Alabama, and Maryland) to develop and test the criteria. The PROs also play an integral role in developing, implementing and evaluating alternative educational outreach strategies based on the BPH guideline.

The project has tested these quality measurement tools with a random sample of medical records of Medicare patients and successfully targeted a number of opportunities for quality improvement. Although the acute pain guideline recommends the development of a preoperative pain management plan in collaboration with the patient, only 7.5 percent of the cases examined met that recommendation. Similarly, the guideline calls for the use of a scaled pain assessment instrument, which was found for only 34 percent of the cases. Yet, length of stay was significantly lower among patients whose care complied with these two guideline recommendations. Thus, complying with the guideline can reduce costs, as well as improve quality.

A number of PROs are working independently to incorporate recommendations from AHCPR-supported clinical practice guidelines into their Medicare review activities. For example, a beneficiary complaint that an HMO had denied cataract surgery caused the Florida PRO to initiate a statewide quality improvement project. As a result of this project, three Medicare HMOs changed their criteria for surgery to be less restrictive and to conform with the AHCPR guidelines.

HCFA and the Connecticut PRO have collaborated in the first effort to incorporate practice guidelines into the Medicare Quality Indicator System (MQIS). Preliminary analysis from chart reviews for pressure ulcers, following the AHCPR guideline, showed significant opportunities for quality improvement. These findings will become the focus of subsequent review and quality improvement interventions.

Several projects place special emphasis on quality issues in managed care settings. For example, two grants will use continuous quality improvement and other techniques to implement and evaluate the effects of guidelines on hypertension and depression in HMOs -- the Group Health Cooperative of Puget Sound and the Kaiser Foundation Hospitals. Another project will test the use of CareMaps administered by nurse managers in a hospital-based managed care system. The intent is to increase efficiency without decreasing effectiveness or patient satisfaction.

The Patient Reports on System Performance (PROSPER) is a measurement tool based on objective information, reported by patients, that can be used to assess the technical quality of services provided, emphasizing access, coordination, and continuity of care. Under the leadership of Dr. Heather Palmer, from whom you will hear later, it was designed for demonstration in multi-site HMOs and permits comparison of performance rates across time and sites.

We believe these projects are of special importance, given the rapid changes occurring throughout the health care system, the increasing enrollment in managed care and its associated incentives, and the difficulty experienced by many managed care organizations in generating the information needed for quality measurement and improvement.

Until now, there has been no single source of information available on clinical quality measures, nor have there been any generally accepted criteria for evaluating the validity or usefulness of the various measures. In addition, many measures do not adjust for special populations or for level of risks. For example, if a hospital or a health plan has a low incidence of low-birthweight babies, is that an indication of that organization's strength in the area of prenatal care? Or does it mean that it does not reach and treat high-risk populations?

For these reasons, AHCPR has undertaken a joint project to identify and describe existing clinical performance measures. Conducted by the Center for Health Policy Studies of Columbia, Maryland, and the Center for Quality of Care Research and Education at the Harvard School of Public Health, the project is really a two-step process. The first step, which is completed, is to take what essentially is a snapshot that will tell us what measures exist and are in use -- and to provide structure for this information, organizing it according to performance measurement sets, clinical conditions, and relevant populations. To date, over 1200 individual measures have been identified. Analysis of these measures reveals that those developed under governmental auspices have been more rigorously tested for validity and reliability than those developed by the private sector.

The next step for AHCPR will be to expand, verify, and refine this classification scheme. Ultimately, this effort has the potential to provide the foundation for an ongoing national resource of validated quality measures, which in turn will assist in quality measurement and improvement and lead to better health care. Many organizations could benefit from such a resource, including HCFA, the National Committee for Quality Assurance (from whom you will hear later), and various other public and private sector purchasers and providers. This provides an ideal opportunity for a public-private partnership, which we are currently exploring.

Improving Consumer Choice

Finally, let me turn to consumers. Today's consumers are too often faced with difficult choices and too little information. First, they must decide whether to purchase health care coverage. Second, to make a choice, they must rely too often on inadequate information. The consumer is frequently left unable to evaluate the quality of the plan or the value it provides.

To assist in filling that void, AHCPR has undertaken, with the help of the Research Triangle Institute, an effort to inventory existing questionnaires that gather information about consumers experiences with the health care system. The objective is to produce a set of standard questions for assessing consumer attitudes about the accessibility, quality, and effectiveness of the care they receive, as well as their satisfaction with that care. A unique feature of this project is that it is being designed to reach a variety of consumer groups -- including heavy users of health care, Medicaid recipients, and others who might have difficulty negotiating the system.

The initial developmental phase of this project is complete. On March 10, we announced a solicitation for the next phase, which involves further field testing and evaluation of model questions in a variety of settings. The intent is to try out the questions in real situations where people are making decisions about their health and health care and to systematically examine the results. We will also make the survey available to organizations who want to begin using the model questionnaire more immediately while the formal evaluation is completed. Both these efforts have involved the private and public health care sectors, in hopes of furthering consensus on what might become an acceptable industry standard.

Conclusion

Let me summarize by reiterating four main points. First, all elements of the Public Health Service are committed to improving the quality of care provided to all Americans. Given the rapid changes that are occurring through the entire health care system, we have a special commitment to assure access to and quality of care for vulnerable populations, including the elderly and low income groups. We have already demonstrated that in many instances lowering health care costs can be accomplished while improving quality.

Second, we need a stronger science base and better tools to learn what aspects of personal health care can be improved and how to do it. Just providing more and better information is not the answer. We also need to strive for real world behavior change. Only when that occurs will we see improvements in quality and cost savings.

Third, we have an important obligation to communicate with consumers, to better understand their needs, and to help them make more educated choices about their health and health care services.

Finally, we are committed to working with the Health Care Financing Administration in its pursuit of high quality care for its beneficiary populations. We have been collaborating along many fronts, as I hope my comments have illustrated. And we anticipate many more opportunities for future collaboration.

I can't conclude without noting that the authority for the AHCPR under the Social Security Act needs to be renewed. I believe Medicare beneficiaries, as a special segment of the population, have been well served by the research and guidelines that AHCPR has undertaken. I look forward to working with you to accomplish a timely reauthorization of these provisions for another 5 years.

I would be happy to answer any questions you may have.

Chairman THOMAS. I thank both of you very much. In accordance with the Chairman of the Full Committee's procedure for recognizing Members for questioning witnesses present at the time the meeting began, we will begin with the gentleman from Nevada, Mr. Ensign.

Mr. ENSIGN. Thank you, Mr. Chairman. I want to applaud your efforts, both agencies, on trying to get a handle on what we are doing to try to improve the overall quality of what not only the private sector is doing, but what your agencies are doing as well.

To that end, you put up the bell curve and, obviously, the goal is to shift that to the right. At this point, what kind of evidence do you have that you are shifting the bell curve to the right and, also, have you done a cost benefit analysis of the amount of money that your agency has expended compared to the benefits that we are getting in shifting that to the right?

Mr. VLADECK. I can answer your second question quite easily by saying, no, not at this point, partially because of the time cycles involved. If you are going to measure any lasting benefit, you need to give it a little longer. Partially because it is a complicated thing to do, since we are talking about a large program with many individual projects in it. We have a contract with the Institute of Medicine to examine the overall efficacy of the revised PRO program, but we do not want to get to the game of picking advantageous anecdotes out of this broad range of projects and say this one saved x amount of dollars until we have an agreement with an independent body on what a fair, overall evaluative process would be.

We can point to successes in a number of instances relative to shifting the curve. Again, I think it is fair to say that it takes a while to aggregate those into national numbers or national tendencies. In the instance I cited in one State, we can tell you that the rate of inappropriate right heart catheterizations in 20 hospitals in that State went down about 50 percent. We could also put a savings amount on that although that would not be a fair cost-benefit analysis until you had more data. We can provide some of those anecdotes about shifting the curve. Have they added up to an aggregate effect? That would be a leap that we are not yet prepared to make.

Mr. ENSIGN. That actually was the purpose for my question, because the anecdotes that you bring in suggest the system is working great, but if you are spending a lot more money to get a few of those anecdotes, that should be considered. On paper this sounds great and I applaud the efforts of what we are doing here and want to see it continue, but also to follow up with that, what you are trying to do is measure the private sector. How are you measuring your own success?

Mr. VLADECK. I think over time, particularly as we look at some of the standards of criteria we are seeking to use nationally, we can better measure success. Just to give some simple examples, we will be looking over the next few months at the proportion of beneficiaries who had flu shots during flu season last year.

A lot of PROs put a lot of efforts into outreach to get people to get their flew shots. We have pretty good historical data. We will

see if there is an increase in the number of persons who got the shots. We will have that sort of evaluation.

On our national cardiovascular project, we should have data by the end of this year on the extent to which physicians throughout the country are meeting the three simple sets of guidelines for optimal care of heart attack patients that we are communicating nationally and working with hospitals about.

We will have measures of national outcome for that one particular, although very high-volume, condition by the end of the year as to whether there has been any aggregate change in the behavior of physicians in an area in which there is a lot of professional agreement that if there is change in that direction people will be better off. Just putting a dollar on that is tricky.

Dr. LEE. If you look at some of the areas like the cataract surgery, those reductions are not just related to a few outliners changing their practice. That is related to a change in the practice of many ophthalmologists. We look at the transurethral prostatic surgery. That is not just an outliner phenomenon.

Guidelines on pressure ulcers, we see a number of areas where we believe that we are shifting the curve because the focus has moved completely away from the outlier targeting the individual practitioner and moving to improve both within the hospital and in the ambulatory setting of the whole system.

The results, we feel, from these just focused practice guidelines that have developed following the PORTs, and this has all come in the last 5 years since the agency was created, and it developed a more focused approach on outcomes research—I think it is very encouraging and although we do not want to make estimates of cost savings, one guideline alone on low back pain where the expenditures are estimated to be around $20 billion a year, we believe that we will see very significant savings, one, in the reduction of diagnostic procedures that have proven to be ineffective and in some surgical procedures that have been widely used that have been found in the acute low back situation not to be an appropriate approach.

We will be following that over the coming years to determine the level of savings that are achieved, but the quality of care for the individuals is the other significant factor in that.

Chairman THOMAS. The gentleman's time has expired. Mr. Stark will inquire.

Mr. STARK. Thank you, Mr. Chairman.

Regarding this issue of reliable quality measures, I presume that that applies presumably to managed care under the indemnity program. I presume that there really is, other than the possibility of outcomes research overutilization and that sort of thing, not much more you can do. How long do you think it would take whether it is government or the private sector or university research to develop a reliable quality measure, and I guess that would—that would not mean that it would result in a report card that the average senior could use to their advantage to pick or choose—how is that going to take us or is it available now?

Mr. VLADECK. I do not think the kind of report card on which I would suggest any consumer reliance is there now. Like all good report cards there is a lot of consensus that the ones we develop

for managed-care plans need to have a number of subjects and be multidimensional and we are further along on some of the measures on which we can grade plans than on others.

For example, we have a lot of data, although not a lot of standardization, on customer satisfaction surveys. AHCPR is working on a project to help develop standard norms of customer satisfaction surveys so that there can be some reliance on the objectivity of the information. That is within a year or 18 months, perhaps.

We have been developing standards on how quickly people get appointments, how quickly they get seen, how quickly the phones get answered. That is not a long-term project. On some of the other measures of how well the plan takes care of diabetes patients, or how well the plan appropriately refers people for home care, for example, we are further away from having the criteria by which we could issue grades. I think we are talking about some number of years, not decades in that regard, but I would be reluctant to say it is 4 years rather than 3, or 3 years rather than 5. It will take us within that range of years.

Dr. LEE. It also depends on what kind of investment we make in doing that and developing the encounter-based systems within managed care. In the absence of those, it will be very difficult and slow in coming.

Mr. STARK. Doctor, isn't there a major difference between applying the standards you could apply to magazine subscriptions, how fast you answer the phone, how long you wait, that doesn't have a lot to do with the kind of treatment you are going to get.

If you wait an extra half hour, you may be mad, but if they cut off the wrong leg you will be a lot madder. It seems to me that reviewing how patients are treated, particularly those that live, is one very complex issue as opposed to just how quick the bills go out and whether they spell your name right, whether people are friendly or the rest rooms are clean—those same things could apply to movie theaters in the mall.

The real question is how do you study whether the person was treated properly or referred to the right specialist? Will that take longer? Are not the only standards we have now that are helpful to the seniors, is the 50/50 rule and their ability to leave, to go back into Medicare if the plan goes broke, or it turns out to be a bunch of high binders, they can go back into the fee-for-service. Is that the only protection seniors have today?

Mr. VLADECK. I think it is an important protection, as I suggested in my testimony, although it is not invoked often enough. The PROs do have authority to respond to complaints and investigate individual instances of inadequate care and to review at the second level appeals for inadequate care and they do that.

In addition, we in the past, in previous administrations, did not adequately carry out our responsibilities for systematic reviews of the performance of managed-care contractors in the Medicare Program and we have a number of such reviews underway and are identifying major areas of deficiency that need correction.

I do think the ability to disenroll essentially on a month-by-month basis is an important consumer protection, perhaps regardless of the amount of information the consumer had before choosing

to enroll in the plan, and certainly not one that at the current state of information we would suggest doing away with.

Dr. LEE. We are also working with the private sector to improve the consumer surveys, and to get better outcome studies. You also have to do medical record reviews in these situations until you have a better encounter-based system, but there is a fair amount of research that has been done and I think if we give it adequate support, we can within a relatively few years give the elderly and others who choose a managed-care plan more assurance.

Gail Warden will be here later, who may be able to amplify on that issue as well.

Chairman THOMAS. The gentleman's time has expired.

Mr. Crane will inquire.

Mr. CRANE. Mr. Vladeck, did I understand you to say that you have a study in progress right now at HCFA to compare managed-care plans' performance with fee-for-service?

Mr. VLADECK. No, sir. If I misspoke, I apologize. We are trying to use the same performance measures that we are developing for managed-care plans for performance of the fee-for-service sector as well so that within a period of several years we will have one set of expectations, one set of performance standards, one set of criteria, but we are not doing that yet.

Mr. CRANE. Is that the target date of 4 years that you referred to?

Mr. VLADECK. Target date implies more precision than I am prepared to give. That is the rough range of the amount of time by which we think we will be able to have standards that can be applied fairly to both the fee-for-service and the managed-care sectors, yes.

Mr. CRANE. Very good. Thank you.

Chairman THOMAS. Mr. Christensen?

Mr. McDermott?

Mr. MCDERMOTT. Thank you, Mr. Chairman. I understand that Mr. Kasich is planning to wipe out the quality review part of your operation, Dr. Lee, and I wonder; if that is wiped out, what protection will there be for senior citizens?

Dr. LEE. I do not see that it will be done anywhere else either in the private or the public sector. Because the benefits of this type of research obviously benefit all patients, Medicare patients particularly because of the focus that we have had, but in the absence of that in terms of benefits both in terms of quality, learning about costs and then producing a more cost-effective system. Private plans individually do not have the resources to make the kind of investment that we can by investing collectively through the AHCPR to then benefit both fee-for-service plans, managed-care plans, hospitals, practitioners, consumers—we just do not have in the private sector—within a competitive system, we would not be generating this type of research any more than we would be able to generate support for basic biomedical research.

Mr. MCDERMOTT. What you are saying is that without this agency there will be no coordination of quality of care in this country between plans or between operations?

Dr. LEE. The private sector is doing a lot of coordination, but in terms of generating the knowledge that we need which we can then

apply in these various settings that would not be done. There are not sufficient resources within the individual health plans to do that.

Mr. McDERMOTT. The PRO can enforce its standards in Medicare situations; is that correct?

Mr. VLADECK. That is correct.

Mr. McDERMOTT. The PRO cannot enforce their standards in the private sector.

Mr. VLADECK. That is also correct.

Mr. McDERMOTT. I picked up yesterday's paper—I was reading a long story in the "New York Times" about Milliman-Roberts, a Seattle firm that put out a cookbook about how to run the most efficient HMO. Milliman and Roberts advises in cataract surgery; do one eye, do not do both eyes, because if the patient does not have a job that requires two eyes, you can get by with doing one eye. That is the way to save money in an HMO.

How do you put together—they said they have sold 6,000 copies of this cookbook to various insurance companies—how do you put together your quality assessment with the fact that Milliman and Roberts is being followed like Julia Childs' book throughout the entire insurance industry? How do you measure the quality when that is what is going on?

It seems to me things are going to two different directions, one to save money and another where you are trying to judge quality. Have you seen the book?

Mr. VLADECK. I saw the newspaper story and am sending away for a copy of the book. I think the issue is that we seek to develop standards of appropriate care, or of high quality care, on the basis of the best professional judgments we can get, informed by the most systematic data we can get, without in particular instances reference to whether that is going to save money in the short term or not, because of our sort of simple faith that in the long term better care is better economics. To take an area in which we wanted to develop guidelines while the work of AHCPR was still in progress, we sat down with the American College of Cardiology and other groups of physician and nursing experts on the management of cardiac disease indicators for our cardiovascular project having to do with the use of high-tech medicine such as putting patients on an aspirin regimen if it is not contradicted by coagulation problems. We ran a process in which we tried to get a high degree of professional consensus to have the physicians look at the data in the literature on what was efficacious and what wasn't—Medicare doesn't pay for outpatient aspirin. We do pay for inpatient aspirin. We do not care in that regard.

The fact is that those patients ought to be on aspirin therapy if they do not have bleeding disorders. That was not a doctor working for an actuarial firm setting standards. There was a very high level of professional consensus among leaders in the profession.

Mr. McDERMOTT. The bottom line question is if you have a standard and Milliman and Roberts has recommended something to Kaiser Permanente, who wins in terms of the care of a senior citizen?

Mr. VLADECK. What I think the way in which the system will evolve is that the medical staff or the members of that Permanente

group will be asked to go through a process of evaluating our guidelines and Milliman and Roberts' guidelines and everyone else's and create a record to show that they, as appropriately credentialed physicians, came to their own conclusions with their patients about what the right norm was. That is the direction in which we are headed.

Dr. LEE. Their guideline does not follow the clinical practice guidelines of the panel chaired by an ophthalmologist at the University of Vanderbilt. A million copies of this guideline have been circulated to the profession through a variety of channels and I would hope when you have this kind of an evaluation, it would beat out that kind of so-called cost-effective recommendation with physicians.

I cannot believe that they would adopt a recommendation like that in the face of this highly professional document, carefully analyzed review of the literature which does not recommend one eye at a time.

Chairman THOMAS. The gentleman's time has expired.

This obviously is an area that we are going to continue to investigate because no one wants cookbook medicine. Obviously, you don't have an infinite number of choices which give you a positive quality cost ratio.

Our first concern is to get a structure in place and then not to lock it in rigidly. Problems do not go away; they just change.

The gentleman from Texas.

Mr. JOHNSON. I wonder, when you develop guidelines, how is the Federal Government involved in this directly and why can't our universities and medical schools figure it out instead of Uncle Sam telling them—

Dr. LEE. We only provide funding to support the process. These where not Federal guidelines. They are guidelines with support of the agency but done in the private sector.

Mr. JOHNSON. Why can't the private sector do it?

Dr. LEE. There are a number of guidelines developed by various professional organizations. Many of the subspecialties develop guidelines, and those are in wide use. It was felt, and I think it is the evidence to date suggesting the popularity of this approach, which is a multidisciplinary approach. It isn't just the ophthalmologist looking at the cataract. It is family practitioners and that multidisciplinary part, I think, has been one of the benefits of this federally supported effort. It is a private activity, with a very modest amount of Federal dollars supporting the efforts.

Mr. JOHNSON. I have watched HCFA in action and it seems to me that you guys are more interested in administrative standards, is the I dotted and the T crossed, rather than the quality of medicine, per se.

Mr. VLADECK. I am familiar with the general perception, sir, but I need to talk about specific examples. It is precisely to try to move away from that kind of specification of great detail about expectations about performance, that we are doing with the PRO program. We are not going to have a HCFA guideline or a nationally established guideline for management of heart attack patients.

We are going to communicate through a variety of mechanisms to hospital medical staffs and HMOs some reported consensus of health professionals about the treatment of those resources.

Mr. JOHNSON. So, you are not going to have a national health standard, per se?

Mr. VLADECK. No.

Mr. JOHNSON. That is great, but who is going to determine who makes the decision of who is right and who is wrong and how are you going to control HMOs in that regard?

Mr. VLADECK. The determination, in most instances, because there are clear-cut cases if a patient requires an amputation of the left foot and you amputate the right foot—

Mr. JOHNSON. No, but we read about that happening.

Mr. VLADECK. In most cases the appropriate person to judge the appropriate treatment of a patient, whether in a fee-for-service or a managed-care plan, at the point of service, is the individual practitioner taking care of that patient. What we want to expect and require is that that practitioner is working in an environment where he has available to him or her data about his pattern of practice compared to that of his or her peers, elsewhere in the community and elsewhere in the State, where he has data about how that pattern looks compared to some professionally accepted norms. We have a high degree of confidence that giving folks that kind of information is the best way to improve the average quality of care being provided.

Mr. JOHNSON. The government is an information supplier, period?

Mr. VLADECK. Also, we are a requirer that people engage in quality improvement activities. We are just not going to define what an appropriate or correct level of quality is.

Dr. LEE. Supporting the research, look at Jack Wemberg's work on prostate enlargement. That went on over a number of years. Then we had the PORT that reviewed all the literature and then we developed the practice guideline. It is clear that practitioners all over the country are using that without a national standard saying this is what you have to do.

Mr. JOHNSON. Thank you.

Chairman THOMAS. The gentlewoman from Connecticut, Mrs. Johnson.

Mrs. JOHNSON. It has been very helpful to hear you talk about the Department's involvement in the development of your ability and our ability as a Nation to oversee quality in health care and to develop a better way of monitoring health actions and evaluating their impact on health.

I was particularly interested in your comments in regard to the relationship between the work that you are doing and funding and involved in and the work the private sector is involved in because there isn't a managed-care company that isn't as concerned as we are about what kind of quality these integrated systems of care are actually delivering.

It was interesting to hear about the information forum that you are going to hold next month. Could you elaborate a little bit more on the kind of things that the private sector is doing in terms of developing their ability to determine whether integrated systems of

care are delivering quality of care and the kinds of things you are doing?

Are you pursuing different or similar lines? Are you overlapping? Are you in different directions? In the course of that, the impression I am getting from the real world is that private sector care systems are developing a far greater ability to allow physician involvement and to honor physician decision. They are not doing the kind of thing they were doing 5 years ago where someone on the telephone told them whether or not they could provide *x* kind of care.

It is a much more developed and sophisticated system that allows a lot more physician involvement, both in guideline development and in care decisions. Just in looking at what you are doing versus what the private sector is doing, since a lot of what you are doing is governing physicians and fee-for-service structures, what is comparable, what is different, how you have to proceed since you are governing a fee-for-service system in a way that is different than the private sector is proceeding because they are looking at systems of care—I am interested in greater depth on the public-private comparison.

Mr. VLADECK. We spend a lot of time talking to private sector buyers and to both managed-care plans and institutions in the fee-for-service sector about what is going on in the private market as well as about what we are doing. I think there is a considerable amount of convergence, in that while it is true that in some ways we are a little bit behind some of the private sector buyers in the monitoring of managed care performance, on the other hand, we have certain advantages in performing those functions that they do not.

Many of them expressed to us considerable frustration and concern about the availability of data, for example, for managed care plans. We have substantially more authority to collect the data than they do and a large enough piece of the action, in most instances, to have a statistically reliable look at certain things.

I think in several areas there is considerable convergence, certainly around some of the objective measures that tend to get talked about in terms of report cards. We are working with the National Committee on Quality Assurance and their HEDIS report card in both the Medicare and Medicaid setting and moving toward convergence in that regard.

In the development of indicators in preventive services, we work closely with the managed-care industry. In terms of patient satisfaction measures developed primarily through AHCPR, we are working very closely with the larger buyers. We are ahead of the private sector in terms of development of particular quality indicators and there, again, frankly, we are increasingly drawing on our experience and knowledge from the fee-for-service sector to develop indicators that we can then test and see if they are applicable and appropriate in managed care and I think the private sector is watching some of that activity with great interest.

Dr. LEE. All the agencies are now involved with managed-care health plans in one way or another; the Centers for Disease Control, for example, in prevention. We are holding a series of working meetings with representatives of managed-care plans and

the Office of Health Promotion and Disease Prevention is working with about 20 medical directors of HMOs to put prevention into practice.

In some cases, they use the HEDIS guidelines. In other cases, they take putting prevention into practice documents and apply those in different settings. There are multiple examples and we would be glad to provide for the record the collaborations that are now going on between managed-care plans and local health departments, for example, to improve the health of the populations in those areas, Milwaukee and Seattle, and a number of other areas, and we have cooperation with the AHCPR and the GHAA.

We have a research conference coming up. They are working with Kaiser Permanente on the implementation of guidelines.

Mrs. JOHNSON. I appreciate that. I hope that there is the same kind of intensive relationship with managed-care plans, because I think you are right, Mr. Vladeck, that the government does have a position that enables us to drive the data collection decisions of the entire public and private system. If we make the right decisions in terms of data collection, we will have a better system in the future for everybody, public and private.

If we make the wrong decision, then the private sector will go a different way and everybody will be stuck collecting two sets of data, which has been a common problem in the past decade.

I want to be sure as we move forward on this and I am pleased with your testimony. You are clearly doing what our experience in this area would lead us to do, that in the end we come out with pretty much a single data collection system. It is what has slowed down simplification in a lot of areas.

If you could get back to me on any work that you have done in the area of prescription drugs. Some years ago HCFA funded a study that discovered that a lot of senior hospitalizations were the direct result of too many medications and too many physicians involved and nobody minding this person's medication shop and we developed very good data about how to prevent hospitalization through better management of prescription drugs. To my knowledge, A, I can't find it, B, I don't know that anything ever came of it policy-wise.

Mr. VLADECK. We will get back to you with the information.

[The information was not received at the time of printing:]

Chairman THOMAS. Mr. Cardin.

Mr. CARDIN. Let me thank both of our witnesses for their testimony today and for their work in trying to improve the quality of health care that all of our people enjoy.

One of the difficulties that we have is that it is more difficult to come up with measures of judging the quality of a managed-care program versus traditional fee for service. Both of you, in your testimony, have pointed out the importance of consumer information, better information for the consumer to make a choice as to quality.

If the consumer is empowered, then I think the market will be of higher quality because of the ability of the consumer to make a choice of one of the higher quality providers. That becomes more difficult when you are trying to judge a plan versus fee-for-service providers and the lack of uniform information in managed care is

an obstacle we will have to overcome and you have talked about that in your testimony.

My comment or question is that if an individual is in a plan where they have no choice, if they are in an HMO that requires them to use the providers that are in that HMO, and they are basically in that plan because their employer provides subsidies and there is no opportunity for them to make a choice, should the Federal Government be concerned about that lack of choice by the consumer and should we be considering legislation that perhaps requires, at a minimum, that the consumer be offered a POS option so at least the consumer has some choice and therefore we have a better opportunity to make sure the market really works and the consumer helps in quality assurance?

Mr. VLADECK. We had some experience last year with suggesting some national rules about the operation of the private health insurance market. It was not an unmixed success so I do not know that—

Mr. CARDIN. This Committee also had some problems in that area.

Mr. VLADECK. I do think that increasingly you will find a perception on the part of folks from all parts of the political spectrum that there should be some basic national standards about consumer protection in health insurance broadly defined—indemnity as well as managed-care plans. Otherwise, we will encounter the phenomenon which we are already seeing of a whole variety of different sorts of State legislation which many of the plans will find less comfortable than some agreed-upon national set of standards and which will also exacerbate the problem of driving more and more employers out of the insurance market, per se, into self-insurance in order to avoid those sorts of things and further fragment and complicate the system.

I think there is increasing recognition of consumer protection issues and the fact that we will get a potpourri of State rules that are all over the place in the absence of some Federal activity in that regard.

Mr. CARDIN. Would you favor, in that national guideline, some protection to guarantee a choice to the consumer?

Mr. VLADECK. Personally, I would feel strongly both about internal mechanisms in all plans relative to grievances, to appeals of decisions about denial of care, the source of care, as well as some degree of choice.

Dr. LEE. To the extent that you can give the consumer the choice of the plan as opposed to the employer choosing the plan—Medicare gives the consumer that choice—that, to me, is the critical issue and then providing the information. Mrs. Johnson made a critical point, we have to have standard data so people can compare.

A report card from one plan may not be the same as one from another. In making those choices, information is critically important.

Mr. CARDIN. What I meant by choice was a choice of plan, as long as the consumer has the ability to get into a plan so there is some weighing of quality and not just the employer making the choice.

Mr. VLADECK. I think that is true. One of the things that all good systems do, whether public or private, is protect people who have made bad choices. The fact that someone has chosen a plan should not eliminate the need for some internal appeals and grievance process.

Mr. CARDIN. You will also need a way for consumers to be able to understand these plans.

Mr. VLADECK. Absolutely.

Chairman THOMAS. I will try to follow up on questions that you have answered so that we can explore it because one of my concerns is the HMO cookbook in terms of procedures. I am struck by the fact that, given the proliferation of the way in which people's health care is being delivered, it is more and more difficult to measure. Sometimes heavy front end on the preventive. It seems to me that in the private sector, to a certain extent, if you hit on something that seems to work, you are less likely to publish it in a book so everybody else can copy it.

It tends to be a proprietary thing and you understand how to manage and save money and you are relatively reluctant to share that with others. I think that is going to be one of the concerns as we move forward in terms of how structures open up and we are able to truly measure what it is that they are doing, because if they are doing a good job they will lose that edge.

Mr. VLADECK. If I may suggest, Mr. Chairman, I think that is also an argument for public support of the development of outcome standards and consensus guidelines about norms of effective service.

Dr. LEE. If we can focus on quality and if the competition is on the basis of quality rather than just price, and that is what I think—it is not a settled issue yet. There is too much emphasis, on instead of managed care, managed cost, and that is a critical issue because you can underserve populations whether fee-for-service or capitation and only by having adequate quality measures and comparing on the basis of quality will we protect the consumer in the end.

Chairman THOMAS. On your bell curves, as you indicated, clearly we are moving away from what you should not do to what you should do and I do not think we should focus on the front end of that curve either. You concentrated in the center of the bell and then moved the bell to the right.

Sometimes we get carried away with the extremes and that becomes our anecdotal chemicals. My concern is that when you are dealing with quality versus cost information it is extremely important. Sometimes too much information becomes chaos in that when you are providing a very long checklist, you begin to look at choosing a health care provider like an IRS form. We have to watch that as well.

Sometimes an agency, probably of the government, that has a degree of trust could have a Good Housekeeping seal of approval approach so that you know that you have met the minimum standards and then leave it more up to the person using choices that are not necessarily objective, but feel good to them. That is our basic goal rather than the front end of that bell curve.

There was a discussion on the 50/50 which protects beneficiaries. There is nothing sacrosanct about a 50/50 is there, especially as we look more into managed care?

Mr. VLADECK. I do not believe there is magic to the 50/50 rule. We have a somewhat analogous standard in the Medicaid Program which is 75/25. Once you get below 25, our experience in Medicaid suggests you really are talking about segregated plans, but somewhere between 25 and 50 does not seem to be a lot of difference.

Chairman THOMAS. I agree on the diminished end of it, but sometimes we pick a number and lock into it and sometimes we lose the possibility of gaining additional information if we are not wedded quite so much to that number.

The gentleman from California talked about the movie theater quality—I agree, and the quality, do your feet stick to the floor, yes or no? My other concern has to do with feet in terms of letting people get in and out of programs.

Clearly, the ability to leave a choice is a good measure of whether or not they liked it, but if it is too frequent, for example, if it is on a monthly basis that you can get in and out, how can you run a managed program where if a secretary offended someone they can walk. If you talk about a reasonable timeframe like a year or so or you provide a period of reflection to determine whether or not they want to revoke the decision they made, kind of like what we have now with folks for an election period, that kind of a structure, for example, a year with possible period of revocation would be preferable to a monthly in and out.

Any reaction?

Mr. VLADECK. I understand and agree conceptually. I have to tell you, however, and I would suggest that both today with subsequent witnesses and in other discussions, I was, at first, surprised and now I am accustomed to it to hear the almost unanimous opinion of the managed-care plans that they would rather have an unhappy customer leave than have a customer locked in. I frankly, think for policy purposes at this point in the evolution of all these systems, my instinct is to defer to the judgment of the folks who are operating these programs on the front line.

There is always the actuarial concern that they will use that essentially disenrollment at will to get rid of people as they become expensive—we do not find evidence of that. I would suggest that you ask that same question to folks running the plans because I do not fully understand their feeling, but it is a strongly held one.

Chairman THOMAS. It would seem to me that you would have some kind of a comparable checklist as reasons for leaving so there is an exit interview or something which provides us with some data that we can then utilize. What we get into is statistics about x number of people leaving and OK, they left, and x the number of people that came in. I am concerned that we do not gather information that will provide us with some tool that we can move forward on.

Mr. STARK. Mr. Chairman, could I ask along the line of getting the necessary information for the nontheater type of research? We are going to hear from a witness later today, and I just wanted to check this. Medicare does not have access to uniform patient-encounter data of services provided to its risk populations. They

are available in the fee-for-service sector and used to profile and analyze patient care, but you do not, as this witness will suggest, have available to you the encounter data in managed care in HMOs. Is that correct?

Mr. VLADECK. That is correct.

Mr. STARK. Do you need legislation or do you just need encouragement? It would seem to me that if you don't have that data, you can't compare managed care with fee-for-service. Is this something that would need legislation—

Mr. VLADECK. It is not clear to me that we would require legislation in order to do that. We are addressing the issue by trying to develop a reasonably high degree of consensus of what the data are that ought to be required and we think we can do that under existing authorities. Certainly any expression of interest or guidance from the Committees of jurisdiction and from the Members helps to prod us along.

Mr. STARK. If we think that there is some benefit to managed care plans, but we want quality data and report cards—if you guys cannot get, in effect, the medical records, you can get them from the fee-for-service side but not from the managed-care side, I do not see how you can inform us accurately. I would like to encourage you and if there is anything we could do, it seems to me that data should be available to you, please let us know.

[The information was not received at the time of printing.]

Chairman THOMAS. I want to thank both of you very much. Good luck on your trip out to the coast.

The next panel will be a panel of doctors, Robert H. Brook, professor of medicine and health services, University of California at Los Angeles Center for the Health Sciences, and director of the health sciences program, RAND Corp.; R. Heather Palmer, director, the center for quality of care research and education, Harvard School of Public Health; and Don E. Detmer, professor of surgery and health policy, vice president and provost for health sciences at the University of Virginia.

I want to thank each of you for coming, and would indicate that for purposes of the record, any written testimony will be made a part of the record, and you may proceed in any way you see fit to inform this Subcommittee.

I guess the easiest way is just to start left to right and move across the panel.

Ms. Palmer.

STATEMENT OF R. HEATHER PALMER, M.B., B.Ch., S.M., DIRECTOR, CENTER FOR QUALITY OF CARE RESEARCH AND EDUCATION, HARVARD SCHOOL OF PUBLIC HEALTH

Ms. PALMER. Good morning, Mr. Chairman and Members of the Subcommittee, and thank you for giving me this opportunity. I am a physician, a U.S. citizen, for over 25 years and director for the center for quality of care research and education at the Harvard School of Public Health.

Chairman THOMAS. These microphones do not pick up very well. You need to have it directly in front of you, and speak into it.

Thank you very much.

Ms. PALMER. I recently led a team of researchers in a 3-year demonstration of quality measurement and improvement in Medicare fee-for-service physician office care in three states, and led a panel of HMO physicians and quality of care experts in the Delmarva project to make recommendations for Medicare managed care review by PROs. In a future where Medicare will increasingly offer beneficiaries choices between competing managed care plans, I have four recommendations for the Subcommittee.

First, major threats to quality of care for Medicare beneficiaries relate to the difficulty providers have in keeping up with rapid changes in clinical science. Clinical practice guidelines help providers keep up with advances. To help providers to follow guidelines, they should use guideline-related performance measures to track their progress.

For example, high blood pressure is the most frequent diagnosis for office visits for patients 65 years or more. Treatment is important because reducing blood pressure by a small amount reduces the risk of having a stroke by 42 percent and of heart attack by 25 percent. Prevention of strokes and heart attacks not only saves beneficiaries from death and disability, but it yields large dollar savings on health care. Clinical practice guidelines for treatment of high blood pressure change with new scientific evidence about which drugs in which combinations to use for which patient circumstances. Clinicians or health care plans that use the same drugs year after year soon fall behind in providing best quality at least cost.

The Agency for Health Care Policy Research conducts outcomes research and uses the results to provide clinical practice guidelines that help health care providers to keep up with scientific advances. Most of these guidelines are directly relevant to the care of Medicare beneficiaries. The Agency for Health Care Policy Research will soon publish a handbook describing a method for measuring guideline-related performance as a form of quality measurement. By this means, HCPR, which owes its existence in large part to the leadership of then-Congressman Gradison, is a vital resource for improving quality in the Medicare Program.

Second, beneficiaries should receive consumer reports comparing performance related to clinical practice guidelines to assist in their choices between managed care plans. These reports need to include explanations of guidelines and of related performance measures. The content of the reports should rotate over time over the range of health care needs of Medicare beneficiaries. Consumer reports should be based on national performance measurement sets to assist beneficiaries who receive care, plans who provide care, and businesses who buy care in multiple states.

NCQA, the HCFA, and the AHCPR are already leading in the development of such measure sets.

Third, cooperative quality improvement programs are needed to protect the interests of beneficiaries who cannot make informed choices among managed care plans. Consider a man whose wife of many years died recently of cancer. He is too depressed to read Consumer Reports. Or, a woman who chooses her plan because of its excellent care for high blood pressure but does not consider the plan's neurosurgery services because she does not know that next

year she will develop a brain tumor. Or, a man whose failing eyesight or hearing make him too confused to consider changing plans.

In quality improvement programs, PROs coordinate cycles for health care plans and organizations, feeding back comparisons of performance to each provider. They reveal benchmarks that encourage plans and organizations to strive for the best level of performance shown to be achievable.

The FAA, Federal Aviation Administration, provides a precedent for this. It doesn't simply publish information on crashes and near misses, leaving consumer choice to weed out unsafe airlines. Instead, airlines share information through the FAA on better ways to promote safety so that information on safer flight is not treated as a trade secret. The same approach should apply with regard to safety and health care.

HCFA has already committed the PROs to quality improvement programs, which should expand to include private purchasers in each state.

Fourth, accreditation that monitors internal quality improvement programs within plans should provide the threshhold for plans and organizations to praticipate in Medicare. Consumer reports for performance related to clinical guidelines are needed in addition to accreditation to make visible to beneficiaries the differences among plans that accreditation does not eliminate.

Cooperative quality improvement programs are needed in addition, and should be at the State level, because health care is shaped by State regulation and politics, local health care markets, and the local cultural and business environment.

Accreditation organizations at the national level are not well situated to conduct such State-level programs. Also, there is a conflict of interest between accepting fees for accreditation and accepting fees to provide individualized technical assistance that might improve an organization's chance of being accredited.

In summary, a mix of quality improvement strategies is essential to protect Medicare beneficiaries, programs of internal quality improvement, consumer report cards, and State-level cooperative quality improvement programs. All of these need to relate to clinical practice guidelines, together with accreditation as a condition of participation in Medicare.

The AHCPR is essential to this agenda. I am grateful to the Subcommittee for this opportunity to present my recommendations on these issues which greatly affect the lives of the 36 million Medicare beneficiaries.

Chairman THOMAS. Thank you very much, Dr. Palmer.

[The prepared statement follows:]

TESTIMONY OF R. HEATHER PALMER, M.B., B.Ch. S.M.
CENTER FOR QUALITY OF CARE RESEARCH AND EDUCATION
HARVARD SCHOOL OF PUBLIC HEALTH

Good morning, Mr. Chairman and members of the Subcommittee, and thank you for giving me this opportunity to discuss with you how quality of care can be obtained for Medicare beneficiaries.

Area of Expertise

I am a physician. I have been a U.S.citizen for over 25 years. For 20 years I have conducted research and education concerning measurement and improvement of quality of health care at the Harvard School of Public Health, where I am Director of the Center for Quality of Care Research and Education. I previously served as a Board member of the National Committee for Quality Assurance (NCQA) and of the American Medical Peer Review Association (AMPRA), which represents the Peer Review Organizations (PROs). I am immediate past chair of the American Medical Review Research Center (AMRRC), a research and educational affiliate of AMPRA. I have provided consultation to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). In my testimony before this Subcommittee, however, I do not represent any of these organizations.

Let me briefly summarize three projects in which I led a team of research in work that is directly relevant to the issues before this Subcommittee.

Medicare Fee-for-Service Physician Office Care: the DEMPAQ Project[1]

The project to Develop and Evaluate Methods to Promote Ambulatory Care Quality was a partnership between the Delmarva Foundation for Medical Care (Delmarva), the PRO for Maryland and the District of Columbia, together with the PROs for Alabama and Iowa, and our research team. We established liaisons with the medical societies and medical specialty societies in the three states, and worked with them to develop and evaluate clinical performance measures for six chronic conditions with related clinical services, and for preventive care for Medicare beneficiaries.

Each performance measure is applied to patients with a given condition and relates to a specific aspect of care for that condition. For instance, a measure concerns the percentage of patients with a condition who receive a service that is indicated for that condition. One hundred eleven performance measures were tested on claims data files for approximately 40,000 beneficiaries in each state, and 263 measures were tested on approximately 4600 patient records from approximately 240 physician offices within the three states. The final report of this three-year project was released in July, 1994.

The PROs in these three states are now working with the Health Care Financing Administration on the Ambulatory Care Quality Improvement Project, in partnership with many of the same liaison physicians who collaborated in the DEMPAQ project.

Medicare HMO External Performance Review: the Delmarva Project[2]

The Delmarva Foundation for Medical Care again formed a partnership with our research team to conduct this project between September, 1993, and March, 1995. In the first phase of this project, we worked with a ten-person expert panel comprised of HMO physicians and quality-of-care experts. The panel included NCQA's project director for the Health Plan Employer Data Information Set (HEDIS) project and several physician members of the HEDIS workgroup. In a series of panel meetings and mailings, panel members used a modified Delphi technique to review 23 existing sets of measures including, 268 individual measures, in order to select a set recommended for PRO review of HMOs. Draft reports of this work were sent for widespread review and comment by HMOs, PROs, and consumer advocacy groups.

The report of this first phase, issued in August, 1994, included recommendations for:

- a core set of measures for all enrollees, and two diagnosis-related measure sets (one for diabetes and one for high blood pressure and heart disease);

- a phase-in of data requirements for Medicare HMOs for the data needed to construct these types of measures;

- future interactions between PROs and Medicare HMOs to take the form of HCFA's other cooperative quality improvement projects; and,

• procedures for data transactions between PROs and HMOs to ensure the accuracy of comparisons for performance measures.

Subsequently, we worked with clinical panels of diabetologists, cardiologists, and generalist physicians to develop detailed specifications of performance measure sets recommended for possible pilot testing by HMOs and PROs.

Typology of Measure Sets and Measures[3]

AHCPR contracted with the Center for Health Policy Studies (CHPS) of Columbia, Maryland, who in turn contracted with our research team to develop a typology of clinical performance measures. With CHPS, we collected and analyzed examples of the range of clinical performance measures currently in use. Overall, we collected 1287 measures from 40 different measure sets. We then classified the measures along several different dimensions and created a set of linked databases to store, sort, and retrieve measures. The goal was to assemble information that could assist potential users of quality performance measures.

Summary of Recommendations

In a future where Medicare will increasingly offer beneficiaries choices between competing managed care plans, I recommend that this Subcommittee consider five points.

First, major threats to quality of care for Medicare beneficiaries relate to the difficulty providers experience in keeping up with rapid changes in clinical science. As clinical practice guidelines help providers to keep up with scientific advances, providers should use measurement of performance related to clinical practice guidelines to track their progress toward improvement in quality of care.

Second, comparison of performance measurements related to clinical practice guidelines should be available to assist beneficiaries in choosing between managed care plans. This information should be in the form of "consumer reports" rather than "report cards." These reports should include detailed explanations of guideline recommendations and of the related measures. Content of the reports should rotate over time to cover the range of health-care needs and chronic illnesses experienced by Medicare beneficiaries.

Consumer reports should be based on national performance measurement sets in order to provide comparable information on health care plans and organizations in different states to assist beneficiaries who receive care, and plans who provide care, in multiple states. A national set of performance measure sets is also valued by businesses who buy care for their employees in multiple states. Accrediting organizations are already leading in the development of such measure sets.

Third, cooperative quality improvement programs are needed to protect the interests of those beneficiaries who, because of frailty, the unpredictability of illness, or limited mental faculties, cannot make informed choices among managed-care plans.

HCFA has already committed PROs to this type of program. Cooperative quality improvement programs should expand, however, to involve providers, consumers, purchasers, and quality-of-care experts in each state.

Fourth, accreditation should provide the threshold for plans and organizations to participate in Medicare.

Fifth, the focus of performance measurement must shift toward ambulatory care because it is the type of care experienced by most beneficiaries, and because small investments in prevention and early treatment of disease can spare patients from suffering more advanced disease, and can avert the greater costs of diagnosing and treating more advanced disease. Providing managed ambulatory care is a major objective and an area of special expertise for health maintenance organizations (HMOs).

Keeping Up with Advances in Clinical Science

Quality health care is care that best maintains and improves the health and satisfaction of patients. Quality can be achieved by choosing tests and treatments that best suit each patient's individual

needs, and by managing care so that tests and treatments are provided safely, efficiently, and humanely.

Since the knowledge base and technology of clinical science change often, care must constantly be improved in order to maintain quality. Such change occurs rapidly as a result of research and development funded both by the public and private sectors. Like Alice and the Red Queen in "Through the Looking Glass," providers of health care have to run fast just to stay in place.

In the 1990s we have diagnostic and therapeutic technologies that can save lives, limit disability, and prevent the occurrence and progression of disease. New technologies emerge continuously at a dizzying pace. These technologies may be more effective but are often also dangerous. A provider who doesn't use these new technologies denies patients chances to improve health and well-being. A provider who uses these new technologies inappropriately harms patients. Providers have trouble knowing what are the right things to do, how to do them, and what outcome to expect. All health-care professionals have to struggle constantly to update their skills and their knowledge to keep up with advances in clinical science.

As technologies emerge that can achieve more for patients, health care becomes more complex. With many persons involved doing potentially dangerous things to patients, the possibilities for miscommunications and errors in implementation multiply. Hospital and ambulatory care managers and staffs must continually adapt to change by planning and implementing the use of new technologies. This creates difficulties for safe and timely provision of care.

The continuing avalanche of new diagnostic tests, new drugs, and new procedures requires competent management in order to improve quality of care at an affordable cost. When resources are limited, providers cannot repeatedly add new technologies; they must strive to improve quality by using more wisely the dollars that are available. Differences in competence in management of health care will lead to differences in quality of health care.

With increasing technical and managerial complexity, also, it is easy to lose sight of the caring, trusting relationship that patients seek from their clinicians. Yet satisfying patients depends upon respecting their concerns, and involving them in their own care. Both health care professionals and managers must struggle to preserve a time and place in complex health-care systems for clear communication between patients and those who care for them.

Implications for Medicare

Many Medicare beneficiaries experience multiple chronic diseases. Major threats to the quality of care for Medicare beneficiaries relate to the difficulty that providers experience in keeping up with rapid changes in clinical science for many different diseases.

Let us take just one disease as an example: high blood pressure is the most frequent diagnosis for office visits of patients of 65 years or more.[4] In the Delmarva study, we found that 37% of the elderly patients randomly sampled for record review had high blood pressure. Treatment is important because reducing blood pressure by the small amount of 5-6 millimeters of mercury is estimated, using empirical data from large studies, to reduce a patient's risk of having a stroke by 42%.[5]

Every four years, recommendations have changed in response to new scientific evidence concerning which of nine different classes of drugs, in which combinations, should be used to treat high blood pressure, for which patient circumstances.[5,6,7] Clinicians, or health care plans that continue to recommend the same drugs year after year without regard to new scientific evidence, soon become seriously out of date.

Clinical Practice Guidelines, Performance Measurement, and Quality Improvement

It is difficult for practicing physicians to determine, for every disease experienced by Medicare beneficiaries, and for every new piece of clinical science, whether the evidence is sufficient to require changing the care they give to their patients. For instance, in the DEMPAQ data for 1989-1991, we found that 30% of Medicare beneficiaries with high blood pressure were treated with calcium channel blocker drugs. In that time period, these drugs were still recommended as one option for initial treatment of high blood pressure. Just last week you probably saw the news reports about the possibility of increased risk of heart attacks for patients taking these drugs.

Obviously, physicians should not change patient treatments on the basis of news reports or even of incompletely digested scientific publications. That is why clinical practice guidelines are needed. When experts weigh the accumulated evidence from clinical trials and from outcomes-effectiveness research about what works and what is safe, they can issue recommendations that help providers keep up to date with scientific advances.

Guidelines for care of high blood pressure are issued by the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure.[5,6,7] AHCPR has issued many other guidelines directly relevant to the care of Medicare beneficiaries, as have many medical specialty societies.

As providers use guidelines in deciding what is the right thing to do for patients, they should measure their performance related to clinical practice guidelines as a way to monitor the quality of care. It is important to understand that performance measurements concern what is done on average, for many patients. We should not expect that guidelines will be followed slavishly in every case because they cannot apply to every patient's circumstance. Indeed, some patients may decline to accept a service recommended by a guideline. Yet, over time, if the percentage of eligible patients experiencing care that conforms to a guideline is increasing, this is an indication that care is improving.

Leading managed-care organizations already internalize practice guidelines, re-design their delivery systems to facilitate following guidelines, and then track progress toward quality improvement by measuring guideline conformance in repeated cycles over time.

The DEMPAQ project demonstrated a similar model that works in fee-for-service office practice by measuring average performance related to clinical practice guidelines for randomly selected volunteer physicians within a state. State medical societies and medical specialty societies worked with their state PRO, the DEMPAQ team and AMRRC to design and conduct physician workshops for quality improvement. The workshops focused on quality of care in those clinical areas where the DEMPAQ performance measurements suggested that improvements were indicated.

The Health Plan Employer Data Information Set (HEDIS),[8] developed by the National Committee on Quality Assurance (NCQA), is an example of guideline-related performance measurement. Other examples are those specified in the two diagnosis-related measure sets for diabetes and for ischemic heart disease/hypertension that were developed in the Delmarva Project for possible testing in HCFA's pilot project in Medicare managed care.

AHCPR will soon publish a handbook describing a method for developing and evaluating guideline-related performance measures. With other research colleagues, I co-wrote this book. We were guided by an AHCPR workgroup of experienced health-care professionals who critiqued successive drafts of the book so as to ensure that it would be practical and useful to a wide variety of users.

I cite these examples to underline for the Subcommittee that guideline-related performance measurement for the purpose of quality improvement is already available as an "off-the shelf" technology, ready for large-scale use.

Guiding Beneficiary Choices: Not Report Cards, but Consumer Reports

Are clinical performance measures also useful for "Report Cards" for consumers? I believe that consumers will find clinical performance measures of great interest if they are presented in an understandable format. Many of the "Report Cards" used to date are too black and white, contain too few measures, too little clinical information, and fail to address different consumer needs and preferences. Consumers need something more like "Consumer Reports." "Consumer Reports" on automobiles give detailed accounts about different types of vehicles that may meet the needs of different groups of consumers, e.g., family vans, light trucks, luxury sedans, and small town cars. For each type of vehicle, desired attributes are displayed in tables or diagrams, e.g., safety, speed, reliability, interior space, comfort, and appearance. The accompanying text educates the consumer about the potential importance of each feature and how it is measured.

Similarly, performance measure sets need to cover clinical conditions of interest to different beneficiary groups. Reports on clinical performance should include text educating beneficiaries about the care that is recommended for each condition. Performance measures covering the

different aspects of care recommended by clinical practice guidelines should be displayed graphically, accompanied by text explaining how this aspect is measured, and any limitations of the measurement. Measures should be grouped in diagnostically related measure sets (DRMS) as recommended to HCFA in the Delmarva Report.[2]

In addition to measures concerning appropriate use of tests and treatments, consumers will likely value measures that describe timely and hassle-free delivery of care, and clear communication from clinicians. Such measures, based on patient survey information, are also readily available - such as the measures developed by the Picker/Commonwealth Program for Patient-Centered Care, and the PROSPER measures referred to by Dr. Lee in his testimony.

Isn't Accreditation of Health Care Plans and Organizations Sufficient?

Are consumer reports really needed? Isn't accreditation of plans and organizations sufficient? The accreditation offered by both the National Committee on Quality Assurance (NCQA) for HMOs, and by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) for hospitals and health care networks, require the organization being accredited to operate an internal quality improvement program. Accreditation visits then provide oversight of the effectiveness of these programs. However, differences in quality that may matter to beneficiaries exist even among accredited organizations.

Accreditation can set a threshold level of quality but does not eliminate differences in clinical performance among plans and providers. In health care markets, competition cannot favor those who perform clinical care better unless these differences are made visible to beneficiaries. This reasoning supports the use of consumer reports for clinical performance measurements.

Consumer reports on clinical performance add value beyond that provided by accreditation specifically if they include multiple diagnosis-related measure sets. Presumably, a Medicare beneficiary will seek a plan that serves elderly persons well and will not be interested in the plan's performance on child care or prenatal care. If this beneficiary has high blood pressure, she will be interested in how well the clinicians in a plan treat high blood pressure, how well they monitor for adverse effects of this therapy, whether they explain to enrollees how to take these medications and how well the plan promotes lifestyle changes that help to control blood pressure. If she does not have diabetes and has no family history of diabetes, she may feel that a plan's performance on diabetes care is not relevant to her choices.

In fact, of course, the leading accreditation agencies, both the JCAHO and NCQA, are leaders in developing and testing sets of performance measures that can be used to compare health care plans and organizations. A feature of both these sets of measures is that they are developed for use nationwide. This is important because both Medicare and many corporations purchase health care in multiple states. Many health-care plans also cross state boundaries. Having national measure sets avoids the burden of collecting and interpreting measurement data that differs from state to state. Also, many Medicare beneficiaries receive health care across state boundaries, because they live in cities that cross these boundaries or because they spend winter months in warmer parts of the U.S. — for them also having national quality measurements is an advantage.

Are Report Cards Enough? The Case for Cooperative Quality Improvement Programs

For competition based on informed consumer choice to ensure quality of care, consumers must be able to understand and act upon consumer reports of clinical performance. There are many reasons why such market mechanisms will be inadequate to protect quality of care for all Medicare beneficiaries.

For instance, consider a man whose wife of many years died recently of cancer; although she died in part because of the poor care that she received, he is too depressed to read consumer reports or to choose to leave his health plan.

Or recall the woman we considered above who chooses her health plan because of its excellent care for high blood pressure; she doesn't consider the poor quality of the plan's neurosurgery services, because she does not know that next year she will develop a brain tumor.

Or consider a man whose failing eyesight and hearing, untreated by his current health-care plan, contributes to his tendency to become confused. The lack of care itself hinders him from using consumer reports to make informed choices.

These examples illustrate why some mechanism in addition to consumer choice is needed to protect the interests of those beneficiaries who, because of frailty, the unpredictability of illness, or deteriorating mental faculties, cannot make informed choices among health-care plans. Cooperative quality improvement programs, like those that HCFA has initiated through the PRO program, are designed to provide this needed protection for Medicare beneficiaries.

There is already a federal government program that provides a model for cooperative quality improvement in health care, namely, the Federal Aviation Administration (FAA). The FAA does provide consumer reports. However, for reports of airplane crashes and near misses, the FAA does not simply publish the information and leave it to consumer choice to weed out unsafe airlines. Instead, the FAA works with all airlines together to devise the best means to protect passenger and crew safety. In other words, airlines do not compete on safety but only on the "amenities" of air travel. Airlines share information through the FAA on better ways to promote safety so that information on safer flight is not treated as a trade secret. The same approach should apply with regard to safety in health care

How Do Cooperative Quality Improvement Programs Work?

In cooperative quality improvement programs, external quality improvement agencies coordinate cycles of performance measurement for health care plans and organizations, feeding back comparisons of performance to each provider. The comparisons reveal "benchmarks" that encourage plans and organizations to strive for the best level of performance shown to be achievable. Alternatively, the external agencies may encourage all providers to improve beyond existing levels of performance, if all are performing below levels that are achievable with use of effective health care.

Each plan or organization then prioritizes areas for quality improvement and may conduct related, but more detailed, performance measurements to direct quality improvements. The original measures can subsequently be re-used within the plan or organization to evaluate the impact of any changes that were made.

HCFA has already committed PROs to this type of program. Cooperative quality improvement programs were also recommended in the Delmarva report as an appropriate mode of interaction between Medicare HMOs and PROs. The report recommended these activities for PROs:

- act as advocate on behalf of HCFA and Medicare beneficiaries, communicating quality-of-care requirements to plans in the form of performance measures and target levels of achievement;

- act as a catalyst for and facilitator of internal continuous quality improvement (CQI) activities in plans by focusing attention on "cooperative projects" that would involve all plans in a state, by providing benchmark performance data, and by providing technical assistance to plans with limited CQI capabilities;

- act as a manager of data collection and analysis services by auditing the accuracy of sampling, administrative data analysis, and medical records abstracting, and providing broad based technical assistance.

There are two reasons why the accrediting agencies, as presently constructed, cannot readily perform these roles. Firstly, there is a conflict of interest between accepting fees to provide accreditation services and accepting fees to provide individualized technical assistance that might improve an organization's chances of being accredited. Secondly, accreditation agencies, at least at present, are national level organizations, and cooperative improvement programs should be conducted at the state level because health-care delivery is shaped by state regulation and politics, local health-care markets, and the local cultural and business environment. This endorsement of state level cooperative improvement programs does not weaken my earlier support for the national performance measurement sets created by the accrediting agencies. National measurement sets should be used in state-level quality improvement programs.

Given the importance of the local environment, and the need to avoid duplicative efforts, cooperative quality improvement programs should involve providers, consumers, purchasers, and quality-of-care experts in each state.

Accurate Comparisons of Clinical Performance

If performance comparisons are to guide beneficiary choices, it is critical that the comparisons should be accurate. The only thing worse than no comparisons is misleading comparisons. Information that misleads consumers not only wastes resources but may provide perverse incentives that actually distort markets. Ensuring a level playing field for comparison imposes the stringent conditions discussed next. The General Accounting Office (GAO) reports that these conditions have not been altogether met in several large scale private sector quality measurement initiatives.[9 10]

Data Availability and Accuracy

Clinical performance measurement requires accurate data about the care experienced by patients; this data must contain considerable clinical detail about the services provided and the patient's health state at different points in time.

In the fee-for-service sector, Medicare's National Claims History File provides an overview of services provided to all beneficiaries, in all settings of care and in all geographic locations. This database does not contain information on care provided within inpatient institutions, nor of services that Medicare does not cover, such as prescription drugs. Nevertheless, we were able to use this data in the DEMPAQ project to create several informative measures of care. Similar measures could only be created for managed care settings if HCFA were to phase in some minimal data requirements for Medicare HMOs comparable to those already in use in the fee-for-service sector. Such a phase-in of data requirements was, in fact, recommended in the Delmarva project report. Pharmacy databases, unavailable in fee-for-service Medicare, are quite widely available in Medicare HMOs and are useful for clinical performance measurements.

In the DEMPAQ project, we were able to create many clinically meaningful measures of performance by abstracting data from physicians' office records for patients and physicians sampled from the Medicare claims data. There is a widespread opinion that record-based measure sets are "too expensive"; this opinion appears to be founded on the unjustified assumption that large numbers of records must be abstracted. In the DEMPAQ project, each patient record obtained was tested against 263 possible performance measures, with an average of 22 applying to any record. Reliable estimates for average physician performance in a state could be obtained with samples of as few as 300-500 records. A cost analysis showed the average cost of applying the 263 measures to a record to be approximately $44. Allowing for costs of sampling cases, we estimate that the cost of obtaining a set of measures of average performance for a state (or by inference, for a large health-care plan) at $50 per record, would be up to $25,000 per measurement cycle.

In the Delmarva Project Report on External Performance Review for Medicare HMOs,[2] two diagnosis-related measure sets were recommended to HCFA, one for diabetes and one for high blood pressure and heart disease. Some measures in each set derived from administrative data, but more derived from patient records data.

The Delmarva report also recommended a rich selection of performance measures based upon patient surveys for consideration for external performance measurement of Medicare HMOs.[2] The report notes that surveys could not currently be conducted by HCFA because of restrictive regulations. Since surveys that obtain adequate response rates have relatively high costs per survey, the report recommended that surveys should also be sent only to samples of patients selected using administrative databases. Administrative databases would, therefore, be needed to sample beneficiaries to create both patient records-based or patient survey-based performance measures.

Verification of Measures

In a competitive market, some neutral party is needed to verify the accuracy of performance measures reported by each health-care plan or organization. Ensuring comparability of data and comparable computation of measures from different health-care organizations requires considerable technical expertise in conducting data audits. The Delmarva report recommended that PROs could provide this service.

Allowing for Patient Differences

When comparing performance measurements among health-care plans and organizations, it is important to account for differences in the patient populations that they serve. For instance, since it is more difficult and costly to give care to sicker patients, it is unfair to make comparisons without

allowing for differences among plans in the severity of illness of their enrollees. Failure to allow for these differences provides perverse incentives that would encourage plans to avoid accepting such enrollees or to avoid providing necessary services to them.

Patient differences that must be accounted for relate to personal characteristics such as age, gender, and patient preferences concerning risk-taking, clinical characteristics such as diagnoses and severity of illness, as well as characteristics related to health care use such as length of time enrolled in an HMO, and whether hospitalized, in a nursing home, or on home care. The Delmarva report recommended special studies of enrollees who disenroll, because disenrollment may reflect dissatisfaction with the care provided.

Difficulties in Using Patient Health State to Infer Quality of Care

Comparisons among organizations and health-care plans are problematic when patients' state of health after receiving care is used to infer whether the care given was of good quality. Such measures are only interpretable for diseases with relatively high rates of death, complications, or severe impairment. In addition, death, complication or impairment must occur close in time to the care given, large numbers of patients must receive care for this condition, and adequate measures of severity of illness for this condition must be available. Given the present state of the art, this restricts performance measurements based on patient health states to a few relatively acute and severe conditions that generally require hospital care.

For the large volume of ambulatory services that make up the bulk of managed care, it is currently more meaningful to use guideline-related performance measurement. The fact that the guideline recommendations themselves are based on clinical trials and outcomes-effectiveness research is sufficient to ensure that improved conformance to guideline will yield improved patient health.

It is particularly difficult to infer quality of care for many conditions using patients' own assessments of their health state. For instance, patients' reports of their health state give misleading impressions about quality of care for preventive care. Patients receiving immunizations and screening tests do not experience symptoms of the condition that care is intended to prevent; therefore, patient reports of their health state cannot be used to detect any difference in the short term between health-care plans that give adequate preventive care and health-care plans that give none.

For another illustration of this difficult but important point, let us think again about the example of high blood pressure. Patients may not experience symptoms from high blood pressure even when the blood pressure is high enough to increase the risk of stroke and heart attack manyfold. Paradoxically, treatments that reduce blood pressure and reduce the risk of stroke and heart attack may make patients feel worse because of side effects of the medications.[11] In this example, a health plan that treats patients better in terms of reducing long-term risks of death and disability would appear worse on performance measures based on patients' reports of their health.

A better measure of performance for high blood pressure would be to measure the percentage of patients receiving guideline-recommended therapies. As an alternative, the average level of blood pressure among enrollees being treated for high blood pressure could be used if adequate allowance can be made for patient differences in severity of their untreated high blood pressure, or if the average level of blood pressure is compared to the average intensity of treatment. For example, we first measure the average blood pressure level for enrollees under treatment for high blood pressure in a plan; if this level is high relative to other plans, we are concerned. However, if a plan with a worse average blood pressure level is performing better on average in the aggressiveness of therapy, we can infer that this plan's enrollees suffer disproportionately from a form of high blood pressure that is more difficult to treat. We conclude that this plan is a high-level performer despite the fact that it serves a sicker population.

Focusing on Ambulatory Care to Improve Health and Avert Costs

Performance measurement must include ambulatory care because it is the type of care experienced by most Americans. In 1990, approximately 78% of Americans contacted a physician in an ambulatory setting, while only 8% experienced a hospital admission.[12] The average Medicare beneficiary has five ambulatory care visits in a year.[4]

Ambulatory care is also vital because small investments in prevention and early treatment of disease can spare patients from suffering more advanced disease, and can avert the greater costs of diagnosing and treating more advanced disease. For instance, HCFA's Cooperative Cardiovascular

Project is an innovative approach to an important problem - improving hospital care for Medicare beneficiaries who experience heart attacks; but improved prevention of heart attacks is also important. For patients with high blood pressure, the risk of a heart attack can be reduced over time by 25% by a small reduction in blood pressure of 5-6 millimeters of mercury, according to an estimate based on large studies.[5] Projects that improve care for high blood pressure in the ambulatory care setting are needed, therefore, in order to prevent heart attacks from occurring at all.

Lastly, the focus of performance measurement should shift toward ambulatory care because managing ambulatory care is a major objective of and an area of special expertise for health maintenance organizations (HMOs).

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Chairman THOMAS. Dr. Brook.

STATEMENT OF ROBERT H. BROOK, M.D., PROFESSOR OF MEDICINE AND HEALTH SERVICES, UNIVERSITY OF CALIFORNIA AT LOS ANGELES' CENTER FOR THE HEALTH SCIENCES, AND DIRECTOR, HEALTH SCIENCES PROGRAM, RAND CORPORATION

Dr. BROOK. I would like to thank the Chairman for inviting me to come.

I would like to begin from two perspectives. First, I am a physician, a geriatrician—I take care of elderly patients, and I actually deal with these issues of cost and quality on a day-to-day. Second, I have spent the last 20 years of my life developing measures of quality of care and health status.

When I, as a physician, go to see my physician, and I am sitting in the room with all my clothes off, wearing a robe that does not cover all of my body, I am not exactly in a powerful position. I do not have the information the specialist might have about my disease. It does not matter who you are, the bottom line for all of us when we go to see our physicians, and all of us will get sick, is that we want a quality product. We want value for our money and we want the quality of care to be excellent.

The real question facing us as we change the medical system through competition, through market forces, or through any other mechanism, is whether quality will someday be as important to the agenda as cost. There is no question that cost and price will remain a concern, but in order for us all to get a product that increases in value, quality must remain on the agenda.

My second perspective on quality of care comes from the research I have done in this area. We have made a lot of progress through both the Agency for Health Care Policy and Research and its predecessor, the National Center for Health Services Research and Development. Today, we are able to measure mental, physical, and social health and the quality of health care provided to patients.

We have measured the appropriateness of care—that is, whether patients need the procedures they receive and whether they are not receiving procedures they do need—by measuring whether the health risks exceed the health benefits. We can also measure how well a procedure is performed, that is, I can tell you whether or not it is done in a technically competent manner.

We can also measure consumer satisfaction with care.

All of these aspects of health care are measurable. The question at the moment is whether we want to make a commitment to measuring them and, when we reform the marketplace through competition, whether the institutions and organizations that produce more value for money or better quality of care will be the ones that survive.

Now, in this marketplace, what should the Federal role be—or should there be any Federal role in this marketplace? I have spent the last 10 years trying to get managed care organizations, business, and the government together to try to form coalitions to develop tools to measure quality of care.

I can tell you that the private sector is not willing to spend the money to develop the tools that are needed. Part of their reason for

not doing so is that the tools for measuring quality are a public good. If one group spends money to develop tools and puts them in the public domain to be used by everyone else, other groups that did not pay for the tools benefit substantially? No business in this country operates this way. Thus, it is essential that the Federal Government assume a leading role. In developing the tools by which quality of care can be measured, whether those tools are practical guidelines, performed standards, or even just data collection methods to measure the performance of health plans.

Given the science we already have available, what is reasonable to expect with regard to our ability to develop those tools and apply them to real policy questions over the next several years? First of all, we need an additional $100 million a year to support tool development. This enables us to develop a system whereby we could measure managed health care plans on the dimensions of consumer satisfaction, appropriateness of care, and technical excellence within a 3- to 4-year timeframe. However, it is essential that the private sector and the public sector work closely together if we are to accomplish this goal.

The second area of the science that must be advanced is the behavioral one. We need to develop better information about how to change the behavior of doctors and organizations to make them function better. We know so little about what mechanisms might make doctors and organizations perform better, give us more value for our money.

We know that about a quarter of the services delivered could be eliminated without harming anybody. Why don't we just get rid of them? At the sametime, we know a lot of people do not get services they need and die. Why can't we make these available. We have some indication that, among patients admitted to hospitals in the bottom 20 percent of hospitals, in terms of quality, the death rate is an additional 6 deaths per 100 people admitted.

We need more information about the science of changing behavior and that also requires an additional substantial investment of funds through organizations such as the Agency for Health Care Policy and Research.

We also need to answer the questions that you asked us today. Is managed care better than fee-for-service? If so, what form of managed care is better than fee-for-service? How does market reform work in one part of the country as opposed to another? We can provide accurate answers to these questions in a timely manner. But, again, additional money is needed.

Finally, we need to have an information system that allows people to have better information about the quality of their health care plan, their hospital, and their doctor. Our best guess is that this would require about $10 per American per year—an insignificant amount of money relative to the vast sum of money we spend on health care each year, but essential if we are to develop information systems and methods for analyzing and presenting data that would provide Americans the information they need to help choose wisely among plans, doctors, and hospitals.

Thank you for allowing me to testify.

Chairman THOMAS. Thank you very much. I think you will generate some questions.

[The prepared statement follows:]

TESTIMONY OF ROBERT H. BROOK, M.D.
RAND CORPORATION

I am Robert Brook. I am Professor of Medicine and Health Services at UCLA and Director of the RAND Health Sciences Program. I thank the Committee for inviting me to testify today on quality assessment and improvement in the context of the Medicare program. We are proud of having the most advanced health care system in the world, but we also are paying more than any other country to get that care. Market forces have played a major role in raising both cost and quality. However, the medical marketplace is much better informed about cost than quality, and consequently we get less value from our expenditures than we should.

My purpose is to provide some general comments with regard to maintaining quality of care in the Medicare population as well as in the private sector. Most of my comments are based on research we have done at RAND and UCLA over the last quarter century. I hope that our findings provide some insight into the importance of measuring quality, as well as ensuring that changes in the health care system -- whether through competition, regulation, or cost containment -- are accompanied by a determination to maintain and even improve quality of care.

It is critically important that we understand how changes in the way we deliver care affect the quality of care and the health status obtained by the American people. This testimony will describe the role the federal government should play to assure that the quality of the American health care system is at least as sound in the next century as it has been in this one, and to make individual patients better able to evaluate the quality of care they are receiving. In order to accomplish this, the federal government must provide funds to *first*, to improve the science of measuring and improving quality, *second*, to support evaluations of how changes in government policies and programs affect quality, *third*, to support efforts to make information about the level of quality in managed care plans and other organizational structures available to the public, and *fourth*, to foster quality-enhancing behavioral changes by both the providers and purchasers of care.

Quality of Care Varies Widely

The absolute need for the federal government to participate in the preservation and improvement of quality of care has been underscored by the research findings generated over the last 25 years in the quality of care field. Two of our most relevant findings are concerned with geographic variation in the use of medical procedures and whether or not a given procedure, when it is performed, is appropriate. For example, our research has demonstrated that where you live determines to a large degree whether or not you receive a medical procedure.[1] Our research shows that the use of common therapeutic and diagnostic procedures such as hemorrhoid removal, coronary angiography, endoscopy, or even coronary artery bypass surgery varies as much as 300 percent, depending on the area of the country in which you live. This variation in use cannot be explained by differences in health status or clinical need. Rather, it reflects differences in physician style, and these differences in style have profound implications for both cost and quality of care.[2]

Variation in use, then, leads naturally into the second issue, the appropriateness of procedures. Although we would expect that high-use geographic areas have more inappropriate care than low-use areas, our data do not support this hypothesis. Instead, the proportion of patients receiving a procedure for less-than-appropriate reasons does not vary much among geographic areas. Thus, simply reducing the number of procedures by changing economic incentives (for example, the proportion of the bill the patient pays or the fee collected by the physician) will not reduce the proportion of inappropriate procedures. [3, 4] The RAND Health Insurance Experiment, in which we randomly assigned families to different health insurance plans that varied in the amount of out-of-pocket medical expenses people had to pay, supports this conclusion. [5,6,7] In this study, we found that if care was free, people used more of it, sometimes as much as 50 percent more than people who had to pay half of the cost, up to a preset amount related to their family income. We also found

that some of the additional care in the free plan was beneficial and some was not. In fact, at the end of the study, we found that people who were enrolled in the cost-sharing plans had levels of health status similar to those who were enrolled in fee-for-service plans. On the other hand, increasing the amount that a person had to pay for care resulted in an indiscriminate decline in care. Some people did not receive care that was beneficial and thus suffered health consequences; others avoided receiving unnecessary care that would have been more harmful than helpful and thus improved their health status.

In sum, our research shows that if we are going to contain the growth of health care costs in the United States, as most people insist we must, mechanisms that rely solely on economic and administrative principles will result in the indiscriminate elimination of care that is both beneficial and not beneficial to the patient. We must therefore develop mechanisms and policies that eliminate care that is not needed (or even harmful) to patients while maintaining care that has been demonstrated to be clearly beneficial. In other words, we must work toward ensuring that quality, not just cost and access, is considered when the structure of the health system is altered by forces such as managed care and competition. [8,9,10,11,12] We are relying heavily on market forces to give us more for our health care dollar. However, no market -- health care or other -- functions well if it is ill-informed about quality. The federal government must play a central role in improving the science of quality measurement, in using that information to improve the programs it supports, and in fostering the availability of quality information in the private marketplace.

Providing the resources necessary to maintain a quality health care system will not be inexpensive. Our estimates show a need of two hundred and fifty million dollars a year in new money to improve the science of measuring care, to evaluate the impact of policy changes and market forces on quality, and to improve the science of how we change clinical and organizational behavior to promote better quality of care. In addition, large sums of new operational money -- between $5 and $10 a person -- are needed to facilitate the American people's choice of health care plans and providers in a competitive marketplace. However, compared to the trillion dollars a year this country will be spending on health care, it is a bargain if this money can help ensure that quality of care is maintained in the next century. If this money is not forthcoming, I can almost assuredly promise you that the quality and efficiency of the health care system in America will suffer.

Quality of Care Has Measurable Components

What exactly is quality of care and how can it be measured? Our research has shown that there are three components of quality. The first is appropriateness. By appropriateness I mean that when a person receives a procedure, its health benefit exceeds its health risk. An inappropriate procedure is one for which the benefit to the patient is less than the risk. And finally, if the benefit is about equal to risk, we define the care as equivocal. Clearly, the most desirable care is that for which the benefit to the patient is greater than the risk. Certainly, it would be preferable to discontinue procedures for which care is not beneficial. Some might even be willing to give up paying for care in the public sector if the cost of the care is very large in relationship to the benefit. At any rate, research has concluded that for many procedures, up to one quarter of those being performed could be eliminated without affecting the health status of the American people.[11-17] On the other hand, it is equally true that many people, including those enrolled in the Medicare program, do not receive procedures that would improve their health. [18,19]

The second important component in measuring quality is the technical excellence with which it is delivered. For instance, we want to be sure that when coronary artery bypass surgery is performed the mortality rate is low, there are few complications, and the inserted arteries and veins stay open for a long time. We want to be sure that if an X ray or mammogram is taken, it is of sufficient quality that important lesions can be detected. In essence, it is not enough for a procedure to be appropriate, it must also be performed well.

The third component of quality of care is patient satisfaction. All of us, when we visit a physician or health care facility, would like to be treated humanely and with dignity.

Satisfaction is the component of care that is often most obvious and most easily measured. It simply involves asking patients about their experiences with care. However, it can also be the least valid measure of quality, because without better information about appropriateness and technical quality, patients can be fooled. They can be satisfied with the manner in which they are treated, but they actually may be receiving "care" that is inappropriate or technically very poor, and this may produce undue suffering and even death.

All three of these components of quality can be measured using tools developed over the past 25 years. However, the science of medical care does not stand still. If quality is to remain on the agenda while the health care system is radically changed by competition, cost containment, and regulation, the tools to measure quality must be continuously improved and must be made available in the public domain. As the information base of medicine changes, so must the tools to measure the quality of that care.

Federal Government Can Help Preserve Quality of Care in Four Ways

1) Support the Development of Better Quality Measurement

What roles can the federal government play to make sure quality is maintained or even improved into the next century? The first priority of the federal government must be to ensure that the science of measuring quality is maintained at the highest possible level and that the resources necessary to do this are provided. Public sector funds must be available to improve and develop the tools for measuring quality. And, these tools must be made available to all who have a stake in maintaining quality health care, whether they be managed care organizations, businesses, labor unions, physicians, nurses, consumer groups, or individuals. Unless these tools are available to the public, it is likely that price considerations, not quality, will be shaping the health care system five or ten years from now. And as our research has demonstrated, this will result in the dismissal of a large percentage of care that is necessary and will encourage a flight toward mediocrity.

The government's role in developing tools to measure quality of care has been demonstrated at RAND on numerous occasions. For example, a large federally funded grant from the Health Care Financing Administration enabled us to evaluate how the introduction of the Prospective Payment System affected quality of hospital care for Medicare patients.[20-22] This new hospital reimbursement system was established in 1983 to help control rapidly increasing Medicare costs. Before 1983, Medicare reimbursed hospitals on a cost-plus basis for each component of inpatient care, but under the new system, Medicare now pays a single lump sum for each admission, based upon the patient's diagnosis. To date, the RAND evaluation is the only national clinical evaluation of this program. In our study, we developed tools to measure the process of care, that is, what health care providers did to patients with one of six common medical conditions — heart attack, heart failure, stroke, pneumonia, hip fracture, and depression. We also developed tools to measure how sick the patient was at the time of hospitalization and what happened to patients after the hospitalization was concluded. Our evaluation of the impact of the Prospective Payment System on these dimensions of quality indicated that, by and large, the reimbursement of hospitals prospectively did not result in an overall decline in patient outcomes or in what physicians did to patients while they were hospitalized. We did, however, find one disturbing result: Patients were discharged from the hospital more quickly and in a clinically more unstable condition than before, and a significant number of these patients died unnecessarily. We concluded that if Medicare is going to change how it reimburses hospitals, it is incumbent upon the federal government to ensure that this policy decision does not harm patients. An ongoing evaluation of the impact of the Prospective Payment System on quality is needed, and other studies such as the one I've described should be undertaken, especially if policies to further contain the cost of the Medicare program are implemented.

The tools we developed in this project enabled us to reach another important conclusion. We found that there are wide variations in the quality of care delivered in U.S.

hospitals. A patient admitted with a heart attack to one of the hospitals rated in the top 25 percent of hospitals in terms of quality of care was much more likely to survive than was a patient admitted to one of the worst 25 percent of hospitals. After controlling for severity of illness at admission, we found that an additional six out of 100 patients admitted to a hospital in the bottom twenty-fifth percentile died. This increased mortality rate was due to a lower level of both physician and nursing quality as well as to a lack of available technology such as intensive care units. This research, when coupled with other studies, suggests that perhaps as many as one-quarter of hospital deaths for some common medical conditions, such as heart attack or pneumonia, could be prevented. [23]

The development of methods and tools for measuring and promoting quality of care has just begun to pay off. We are making new breakthroughs every day, and it is absolutely imperative that the federal government provide substantial new monies to the federal agencies supporting this research. I'm thinking in particular of the Agency for Health Care Policy and Research (AHCPR), which bears the primary responsibility for ensuring that quality of care is maintained throughout the American health care system. The research community needs 100 million dollars of new money a year to continue its research on the measurement of quality of care. I contend that the price is well worth the benefits we and our children will reap.

2) Monitor the Effects of Changes in Policy and Markets

The second role of the federal government, as partially illustrated by the above study, is to monitor continuously not only how changes in policy at both the state and national level, but also how developments in the health care marketplace, affect quality of care. In order to eliminate policies and programs that are harming people, or to improve upon policies that do work, we must know not only their effect on cost but also on quality, as assessed at a clinical level. The federal government is the only entity that can provide funding to answer many important questions. For example: Are market forces increasing or decreasing quality? Do African Americans receive lower quality of care than Caucasians? Is the likelihood of surviving a heart attack the same in rural America as it is in urban America? Are we implementing policies that are decreasing the level of quality, or increasing variations in quality, across regions of the country or across ethnic or racial groups? And finally, how do we stack up internationally? Is quality of care better in the United States or Switzerland? In what country would you have a greater likelihood of surviving a heart attack and why?[24] To answer these questions, the research community needs funding support in the amount of $50 million a year.

3) Develop an Information System

The third role for the federal government is to help stimulate in the private sector, or to develop in the public sector, an information system that will provide to the entire U.S. population information about how their choice of a health care plans, and perhaps even their choice of a hospital or doctor, affects the quality of care they receive. Provision of this information must involve the private sector through a private-public partnership. However, its success is critically dependent upon improving the science of measuring quality and making the measurement tools available in the public domain, as described above. The cost for such a system will be 5 to 10 dollars per person per year. Again, research has demonstrated the need for such an activity. Although not relevant to the Medicare population, work we have done with managed care organizations has shown that the quality of prenatal care varies remarkably depending upon which organization one goes to.[25] Similarly, the likelihood that a woman receives an unnecessary hysterectomy varies by the managed care plan she chooses.[26] Finally, research in New York and Pennsylvania has shown that the likelihood of surviving a coronary artery bypass surgery depends not only on the hospital where the surgery is done, but also on the physician one chooses and that higher cost does not guarantee higher quality. [27,28] If such information were available to help people choose in which plan they should enroll, reform based on market forces would consider both quality and cost, and hopefully the better organizations, not necessarily just

the cheaper ones, would survive as cost containment or reduction in the growth of the health care industry occurs.

4) Help Implement Behavioral Change

The final role for the federal government is to increase the fundamental scientific knowledge about how one helps organizations, physicians, or hospitals to change so that they can deliver better care and more cost-effective care. Research by sociologists, economists, clinicians, and psychologists is needed in this area to answer many important questions. For example: How can the productivity of a physician visit be measured? What behavioral techniques work best to produce cost-effective care? What incentives are effective in changing physician and nurse behavior ? Do different organizational structures result in different levels of quality? Answers to these questions will help the health industry produce a better product. An investment of a 100 million dollars a year is needed to improve science in this area. alone would not be too much.

Conclusion

The science of measuring quality of care has come a long way in the past quarter century. This scientific progress owes a lot to the Agency for Health Care Policy Research (AHCPR) and its predecessors. Health Care Financing Administration (HCFA) has sharpened the application of this science through its efforts to improve quality in Medicare and Medicaid, for example, through the PRO program.

It is feasible that within a few years, if our efforts in this area are expanded, the four goals of federal policy envisioned above could be achieved. However, to accomplish this the research community needs at least $250 million a year in new money to improve the science of quality measurement, to evaluate policy and program changes, and to make quality of care information available in the private marketplace. The natural home for these new monies should be the agency which has the mission to perform such tasks, namely the Agency for Health Care Policy and Research.

We *can* develop and implement policies to improve the efficiency and effectiveness and quality of our health care system. We must make a concerted effort to keep quality on the agenda and to make sure that quality and price receive equal consideration. In the absence of information on quality, it is cost that will drive decisions about changes in the health care system. If this is the sole engine by which we alter the health care environment, one thing is certain -- mediocre organizations, mediocre physicians, and mediocre hospitals will be the ones that survive, rather than the organizations, physicians, and hospitals that can make the American health care system the best in the world and the ones to which, when we become sick, we would like to go. We can measure quality of care, we can evaluate how federal and state policies affect quality, and we can help to ensure that the best organizations are the ones that survive in a competitive marketplace, as opposed to those that merely contain costs and restrict the level of technical quality they provide to a level that may harm patients. We can do better, and the government has a vital role in ensuring that we do so.

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Chairman THOMAS. Dr. Detmer.

STATEMENT OF DON E. DETMER, M.D., PROFESSOR OF SURGERY AND HEALTH POLICY, AND VICE PRESIDENT AND PROVOST FOR HEALTH SCIENCES, UNIVERSITY OF VIRGINIA

Dr. DETMER. Thank you. I am pleased to be here. Thank you for this opportunity. I also am a physician and maintain an active practice in peripheral vascular surgery. In addition, I chair the Board of Health Care Services at the Institute of Medicine. I also chaired the IOM Committee on Improving the Patient Record.

I particularly want to respond to your question about ways to best assure quality of care as well as provide to beneficiaries the information they need to make good health care decisions. What should the Federal Government do now to allow us ultimately to secure these ends? First and foremost, the government should make a comprehensive commitment to the computer-based patient record.

Today health care is undergoing a ground shift of seismic proportions. At its best, our health care system delivers professional quality of care. Our Nation is now making a rapid transition to managed care, integrated health care systems, and this change has many positive features, and the country clearly had to do something about our way of organizing and financing care.

It is also true that every American has a lot at stake in these changes, and there is a real potential for strip-mining our health care system. Political leadership will be required to assure that managed care is implemented on a level playingfield with respect to quality; that there be competition on value rather than price alone; and that there be valid public report cards on performance.

One cannot assure the value of anything without reliable and valued data. In looking forward in time, we will not have all the data we need without robust computer-based records and computer-based record systems. Professional quality care is measurable, but its measurement is subtle and complex, including patient satisfaction, cost, and the severity of illness being treated.

If professional care is to be assured in the future, it will spring from continued Federal support and enhanced support of health services research as administered through HCFA, the AHCPR, and a few other agencies. Continued funding of health services research and computer-based records by ACPR and HCFA will be critical.

Computer-based patient records will allow us to monitor care continuously, automatically issue appropriate reminders, provide access to clinical practice guidelines relevant to the case at hand, and take actions to assure better outcomes. With such an approach, our medical knowledge will become progressively more evidence-based and less opinion-based.

Person-specific relevant medical data on a right-to-know and need-to-know basis must be available across the Nation. If a Californian is visiting Monticello and soon thereafter arrives comatose at our emergency room at the University of Virginia Hospital, the outcome of care may well depend on our gaining prompt access to relevant information in her medical record. Similarly, a resident in Washington should be able to access the record of his

own vascular illness to assure its accuracy and participate intelligently in his care.

When the Federal Government commits fully to the CPR concept, we will have a law mandating a policy on confidentiality, privacy, and data accuracy.

Standards would be established for data elements, vocabulary, transport of patient data, and security to protect patient privacy and confidentiality as well as data integrity. Market forces alone will be inadequate to drive standards developments far enough and fast enough. Federal support would accelerate progress to the benefit of all, particularly the marketplace. The government would create discrete identifiers for each individual, health professional, and health institution.

These are key recommendations of the 1994 Institute of Medicine Report on Health Care Data Systems and has, again, surprisingly wide agreement.

Our Nation will have an information superhighway. We must assure that health information crucial to professional quality of care can ride on it. Without prompt action at the Federal level, our State laws and policies will be inconsistent and very tough to straighten out later.

But most importantly, why should some patients suffer unnecessarily when the information exists but we cannot get to it in times of legitimate need?

At times, personal, State, and national answers can only be researched through policies set at the Federal level. Many of us share a vision of comprehensive delivery systems which provide a continuum of high quality services in a cost-effective manner. However, integrated delivery systems without integrated information systems are a misnomer.

Unless and until we develop the medical data systems that provide timely, accurate, consistent, complete and successful data to meet legitimate needs, we will never achieve the level of clinical knowledge that is possible, we will never be cost effective in our care, we will never assure quality of care, nor will we achieve the level of health that the American people deserve.

Thank you for this opportunity to share my views. I will be happy to respond to questions as I can.

[The prepared statement and attachment follow:]

STATEMENT OF DON E. DETMER, M.D.
BEFORE THE SUBCOMMITTEE ON HEALTH

Committee on Ways and Means
U.S. House of Representatives

March 21, 1995
Chairman Thomas and other members of the Committee:

Thank you. My name is Don E. Detmer. I am University Professor ofSurgery and Health Policy, and Vice President and Provost for HealthSciences at the University of Virginia in Charlottesville. I maintain anactive practice of peripheral vascular surgery. In addition, I currentlychair the Board on Health Care Services of the Institute of Medicine. From 1989 to 1991 I chaired the IOM Committee on Improving the Patient Record .

Four years ago, I spoke to this subcommittee about the critical role of computer-based patient records (CPRs) in improving the quality and controlling the costs of health care. I am pleased to be here today to respond to Chairman Thomas' request to hear about "ways to best assure professional, quality care as well as provide to the beneficiaries the information they need to make good health care decisions." I will focus more on the former than on the latter but both are obviously important.

What should the federal government do now? First and foremost, the government should make a comprehensive commitment to the Computer-Based Patient Record. Parts of the government are heavily committed but others are not. The entire government needs to commit to the computer-based patient record by addressing the performance criteria presented in the 1991 IOM CPR Report. {1}

Today, health care is undergoing a ground shift of seismic proportions. The partial list of changes underway are identified on the last page of my testimony. At its best, the U.S. health care system delivers professional, quality care. Our nation is now making a rapid transition to managed care and this change has many positive features. The country clearly had to do something about our way of organizing and financing care.

It is also true that every American has a lot at stake in the outcome of this change, and it is in our collective interest to take all reasonable steps to assure professional, quality care in the future. The coming changes do hold a real potential for strip-mining American health care. The Institute of Medicine recently created a special initiative to keep an eye on what happens to quality in the months and years ahead. Political leadership will be required to assure that managed care is implemented on a level playing-field with respect to severity-of-illness adjustment, appropriate cost-containment, public report cards on performance, and quality through competition on value rather than price alone.

One cannot assure the value of anything without reliable and valid data, and we will not have such data without robust CPRs and CPR systems. Our nation's quality measurement efforts have been based over the years within the Health Care Financing Administration (first through the PSROs and, more recently, the PROs), NCHSR, and more recently, in the Agency for Health Care Policy and Research (AHCPR). These agencies have done yeoman's work developing the methods needed to track our progress and improve medical practice. Health services research is now coming of age and its potential to improve the cost-effectiveness and productivity of health care is beginning to be felt. Most recently, AHCPR has been funding very important work, particularly those projects which link quality measurement to medical informatics (the use of computers to address medical needs of various types).

Continued funding of health services research by HCFA and AHCPR is crucial, especially when one considers the size of the federal government's health care investment. One cannot assume that this work will be done by the private sector. Rather, as one looks forward to managed care, the private sector will more likely become less willing to share data which have substantial proprietary value.

My second observation is that professional, quality care is measurable, but its measurement is subtle and complex, involving a number of relevant dimensions including the process and outcomes of care, patient satisfaction, costs, and the severity of illness being treated. If professional care is to be assured in the future, it will spring from information derived from computer-based patient records and as a result of federal support of biomedical research through the National Institutes of Health and of health services research and development through AHCPR, HCFA, and other agencies.

Third, professional, quality care typically requires an initial investment in order to save money over the long term. For example, if you don't pay the costs needed to sterilize surgical instruments properly, you will pay more later to care for the postoperative infections. The same is true for immunizations and other preventive measures which avoid morbidity.

Fourth, only computer-based patient record systems will allow us to monitor care continuously, automatically issue appropriate reminders, provide rapid access to clinical practice guidelines relevant to the case at hand, and take actions to assure better outcomes. Person-specific relevant medical data on a right- and need-to-know basis must be able to cross the nation. Let me bring this closer to home. If a Californian visiting Monticello arrives comatose at our emergency room at the University of Virginia Hospital, her life may depend on our gaining prompt access to the information in her medical record. Less dramatic but nonetheless important, a resident of Bethesda seen in consultation in my vascular clinic should be able to access his own record to assure its accuracy and to participate intelligently in his care.

Recent studies have shown that when beneficiaries enter information about their own health into a computer-based patient record, the data are more complete and accurate. One recent study documented that, in 81percent of the cases in an outpatient clinic, physicians using current paper-based systems could not find all the patient information they desired during a patient's visit (Tang, Fafchamps, and Shortliffe). The results of missing information are delays in care, repeated diagnostic tests, added patient discomfort or work, and/or decisions made without the full range of needed data. Quality is compromised and costs go up.

It is fairly straightforward to describe how patient data should flow to enhance quality of care. We should be able to (1) capture data as a natural by-product of providing care or at least through one-time data entry by health care professionals; (2) store the data in a retrievable format; (3) transfer data among the various sites of care that serve patients; (4) aggregate the data and provide access to health services researchers for public health and policy purposes; and (5) bring up-to-date research results to the clinicians at the point of care. With such an approach our medical knowledge will become progressively more evidence-based and less opinion-based. I do not intend to imply that any of these steps are easily achieved. Although such an information flow makes eminent sense for health care, it will take a number of policy and technical steps to accomplish this vision.

When the federal government commits fully to the CPR concept, much more will happen in Washington and also across the country. We would see a law mandating a comprehensive preemptive federal policy on confidentiality, privacy, and data accuracy. It would be tough and would result in encryption efforts and substantial penalties for putting one's digital nose in the wrong place. This is a key recommendation of a 1994 IOM report on health data systems, and experts have a surprising degree of agreement on this issue. Such legislation deserves to be a very high priority.

Second, a variety of standards should be established to cover a set of patient data elements, for vocabulary to ensure consistent meaning of patient data, for messaging to allow transport of patient data within and among institutions, and for security to protect patient privacy and confidentiality as well as the integrity of the data. The government would create discrete identifiers for each individual, health professional, and health care institution. Whether the personal identifier is the Social Security Number plus an additional private personal identification number, or PIN,or a totally new number, I don't know. I do know we need discrete identifiers.

Although a lot of time and effort has been devoted to standards, much more remains to be

accomplished. In the U.S., standards development has relied largely on volunteers who fund their own efforts. It is not at all clear that market forces alone will be adequate to drive standards development far enough and fast enough. Federal support through funding, incentives, or even mandates would go a long way toward accelerating this process.

Our nation will have a information superhighway. We must assure that health information crucial to professional, quality care can ride on it. Some of these issues were addressed in several bills introduced during the 103rd session of Congress -- S1757/HR 3600 and S 1494/HR 3137. Without prompt action at the federal level we shall inherit a patchwork of state laws and policies which will be inconsistent and which will be a nightmare to straighten out later. Keep in mind that approximately half of the nation's people receive care across state lines. States have major roles to play in health care but data must be able to move and must be understandable from one state to another. Personal, state and national interests at times can only be served through policy set at the federal level.

Finally, partnerships with the private sector should increase, with the government paying costs at fair market prices to buy needed health care information from health care organizations, including insurers. Further, government should continue substantial investments in research and development as well as informatics education. The other needed standards would allow legitimate work to move forward with resultant improvements in personal health care.

As reliable, accurate data from the point of care are generated, secondary data sets drawn from this information can generate the intelligence needed to wisely inform individuals and the public in general with what they need to make personal choices. The Professional Review Organizations and other national public health agencies such as the AHCPR, the Center for Disease Control, and the Food and Drug Administration will then have the reliable and valid data they need to address their mandates. The results of these efforts will be reinfused into professional activity through the National Library of Medicine and other units of the National Institutes of Health.

And last and only if needed, federal cost-sharing with the private sector should be considered if it is needed to diffuse computer-based patient records across the country at the end of the decade. This might particularly be needed in more isolated parts of the nation if we are to bring professional, quality care by effectively using telemedicine.

Many of us share a vision of comprehensive integrated managed health care delivery systems which provide a continuum of high quality services in a cost-effective manner . Integrated delivery systems without integrated information systems are a misnomer. Unless and until we develop the medical data systems that provide timely, accurate, consistent, complete, and accessible data to health professionals and, the public as appropriate, we will never achieve the level of clinical knowledge that is possible, we will never be cost-effective in our care, we will never assure quality care, nor we will ever achieve the level of health that the American people deserve.

Thank you for giving me this opportunity to share my views with you. I will be pleased to respond to any questions or comments.

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FOOTNOTES**********

{1} According to the IOM committee, comprehensive CPRs and CPR systems should: (1) contain a problem list; (2) support systematic measurement of health status and functional level; (3) document the clinical rationale for patient care decisions; (4) link to other clinical records across settings and across time to provide a longitudinal record; (5) provide comprehensive confidentiality safeguards; (6) offer easy access to authorized users; (7) allow selective retrieval and formatting of information; (8) link to local and remote knowledge, literature, bibliographic, or administrative data bases and systems; (9) assist in the clinical problem solving process; (10) support structured data collection and store data using a defined vocabulary as well as support direct data entry by practitioners; (11) aid in the management and evaluation of quality and costs of care; and, (12) be flexible and expandable.

Basic Transformations in U.S. Health Care

Yesterday	Tomorrow
medical care	*health* care
acute, episodic care	longitudinal, chronic care
inpatient	outpatient
illness	illness/wellness
individuals	individuals and populations
"non-system" health care system	comprehensive, integrated health care system
fee-for-service	capitation
credentials; technology	price, then value
traditional authority	scientific evidence
paper-based	computer-based
MD dominance	multidisciplinary team approach
3° specialist	1°,2°,3° generalist/specialist
basic biomedical research	basic, applied, and health services research
white male leadership	diverse leadership
paternalistic behavior model	collaborative model of behavior

Don E. Detmer, M.D. (10.94)

Chairman THOMAS. Thank you very much, Dr. Detmer. I thank the entire panel. The gentlewoman from Connecticut, Mrs. Johnson, will inquire.

Mrs. JOHNSON. Thank you, Mr. Chairman. I thank the panel for your testimony. You have raised so many questions, it is hard in 5 minutes to know where to start.

First of all, I am absolutely fascinated by your optimism. As an optimist, that is a surprising statement. Two little questions. Does all of this research include VA hospitals as well as for-profit and nonprofit hospitals? And also, can you measure the impact of preventive actions as well as you can measure the impact of illness-related or incident-specific actions?

Anybody who wants to comment on those things.

Dr. BROOK. The answer to the question is that we can measure the effect of preventive care on both cost and health outcomes. We have just published a paper, which we will be happy to send you, on the diagnosis, management, and treatment of early breast cancer. We did various cost-benefit analyses related to mammography screening and we presented the results in a way that provides managed care organizations with information about strategies for managing women that have breast cancer.

Chairman THOMAS. We would very much like to have a copy of that.

[The information follows:]

RAND

RAND/RP-394

Benefits and Costs of Screening and Treatment for Early Breast Cancer

Development of a Basic Benefit Package

Herman Kattlove, Alessandro Liberati,
Emmett Keeler, Robert H. Brook

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REPRINTS

Economics, Costs, Utilization, and Access to Care

Special Communication

Benefits and Costs of Screening and Treatment for Early Breast Cancer

Development of a Basic Benefit Package

Herman Kattlove, MD, MPH; Alessandro Liberati, MD; Emmett Keeler, PhD; Robert H. Brook, MD, ScD

Objective.—To develop a basic benefit package for detection and treatment of early breast cancer by evaluating the effectiveness and costs for screening mammography, primary surgery, adjuvant therapy, and follow-up care.

Data Sources.—Published articles were retrieved through MEDLINE; additional articles were obtained through searches of their bibliographies. Cancer statistics were taken from Surveillance, Epidemiology, and End Results (SEER) Program data, population statistics were taken from US Census data, and charges from 1993 Southern California Medicare fees were used to represent costs.

Study Selection.—Studies were selected on the basis of their design. Preference, in decreasing order, was given to meta-analyses of randomized trials, individual randomized clinical trials, prospective cohort studies, retrospective cohort studies, and case series.

Data Extraction.—Studies were examined for the effect of the intervention on overall survival, disease-free survival, and health-related quality of life. We evaluated effects on survival in terms of number of lives saved at 10 years and average years of life saved. Costs were related to the benefits observed and modeled onto a hypothetical health care organization of 500 000 lives.

Results.—Based on this analysis, we recommend a basic benefit plan for the detection and treatment of early breast cancer that would include the following: (1) screening mammography only for women aged 50 to 69 years; (2) choice of mastectomy or breast-conserving surgery with radiation therapy for all women with early breast cancer; (3) adjuvant therapy for all women at risk of recurrence; and (4) only clinical follow-up without routine testing for metastatic disease.

Conclusions.—By choosing which services they provide to specific groups of patients, providers can substantially reduce their expenses and still provide quality health benefits.

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ONE OF THE recurrent questions in the health care system reform debate is how to define the benefits that should be provided equally to all citizens. Developing such a basic benefit package is difficult. Evidence about health outcomes, patient preferences, and costs is required. Regrettably, it is easier to estimate the expense of medical care than to project the benefit. Assessing patient preferences is equally difficult.

See also p 149.

Bearing in mind all of these problems, we have used an explicit approach to estimate benefits of and expenses for services that are offered to women to detect and treat early breast cancer (found in the breast or axilla only). Breast cancer occurred in 182 000 women in the United States in 1993,[1] consumed more health care dollars ($6.5 billion in 1990) than any other cancer,[2] and has been well studied.

We discuss four main decision points in the diagnosis and treatment of early breast cancer: screening mammography, primary surgery, adjuvant therapy, and follow-up care. We have applied data on the expense and benefits of these four services to a hypothetical health care organization of 500 000 lives in which 360 new breast cancer cases would occur yearly.

METHODS AND ASSUMPTIONS

Literature Review and Assessment of Evidence

We searched MEDLINE for each of the four topics (screening mammography, surgery, adjuvant therapy, and follow-up care) from 1980 to 1993 and added references from other articles and reviews (Appendix Table 1; appendix tables are available from the National Auxiliary Publication Service [NAPS]). For each of these topics, based on a modification of the scheme of the Canadian Task Force on Periodic Health Examination (Appendix Table 2),[3] we developed summary judgments of the strength of the evidence concerning benefits. We assessed the published studies according to a hierarchy that weighted meta-analyses and randomized clinical trials over prospective cohort studies, retrospective cohort studies, and case-control studies or case series.

Costs and Benefits

The costs of services could not be easily defined. As a proxy, we used charges,

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Table 1.—Charges and Benefits of Screening Mammography*

Age, y	Deaths per 1000 Women		Potential Lives Saved per 1000 Screened at 10 y	No. to Screen to Save One Potential Life at 10 y	Charges to Save One Potential Life at 10 y, $†	Potential Extra Days of Life per Person Screened	Charges for Extra Year of Life, $†
	Control	Screened					
40-49‡	1.84	1.98 (1.60)	0 (0.24)	(4181)	(1 460 000)	0 (2.5)	(51 700)
50-59	3.94	2.49	1.45	690	183 000	11.7	8280
60-69	4.63	3.02	1.81	553	146 000	9.8	9890
70-74	5.35	5.35	0	...	...	1.8 §	35 900

*Data taken from Tabar et al, Table 6.[10]

†Charges for mammography and workup of positives (1.5%)=$88.50 ($77 for mammography and $11.50 extra for biopsies), based on "package" of four screens over 7 years for ages 40-49, three screens over 6 years for ages 50 to 69, and two screens over 3 years for ages 70 to 74.

‡Swedish overview[8] found mortality ratio of screened/control=0.87 (95% confidence interval, 0.63-1.2). Numbers in parentheses reflect sensitivity analysis if 0.87 is correct, and 1.84 per 1000 would die without screening.

§Survival of the screened group is better for the first several years, but at 10 years the survival curves of the screened and control groups meet.

namely, Transamerica Occidental Life Southern California 1993 Medicare rates. The benefits for various services are presented for every year (or fraction of a year) of extra lifespan or per life saved. Our use of "the cost of saving a life" is presented strictly for comparison purposes; we do not intend to place a monetary value on a human life.

The extra life span was calculated from the DEALE formula[4]:

$$\text{Gain}=(L/[1+d_tL])-(L/[1+d_cL])$$

where L is the life expectancy at the midpoint of the described interval; d_t, the hazard for treated patients; and d_c, the hazard for untreated patients. This formula was used where the hazards for both groups are known, as is the case for adjuvant therapy. For screening mammography, we estimated extra lives saved at 10 years and extra lifespan from survival curves for the 10 years following screening. Survival curves were derived by using the actuarial estimate given in Miller.[5] When hazards were not known, the extra life span was calculated from the following formula:

$$\text{Gain}=(SG\times NS)+(LS_{10}\times LE_{mp+10})$$

where SG is the sum of the survival gains per person in the 10 years following initial screening; NS, the number screened; LS_{10}, the lives saved at 10 years; and LE_{mp+10}, the life expectancy of average US women whose age is 10 years more than the midpoint of the age range screened. We also used the concept "number needed to treat" of Laupacis et al[6] to determine the cost of saving a life. For example, if a treatment saved one life for every 10 treated, then the cost to save one life would be the cost of treating 10 patients.

Screening Mammography

The only benefit we considered for screening mammography was survival; we did not consider health-related quality of life because such data were not systematically collected in the screening trials. Studies[7-16] of screening mammography found a 30% reduction in mortality for 50- to 69-year-old women who were screened, but no statistically significant benefit for those older than 70 years or younger than 50 years (Appendix Table 3).

To estimate the benefits of screening mammography and the costs of these benefits, we used data from Tabar et al[10] who presented mortality figures by year for women in each of the four age groups in two Swedish counties. Results from the two counties were not significantly different so the data were pooled in a survival analysis (Table 1). We estimated the charge for mammography at $88.50 per person screened. This includes both the charge per mammography ($77) and the charge ($11.50) for evaluating positive mammograms. Data from the United Kingdom study[17] on the specificity of screening was used to calculate this charge. Although the literature does not support a statistically significant benefit of screening on mortality for woman aged 40 to 49 years, we performed a sensitivity analysis based on the 13% nonsignificant survival benefit contained in the overview of the Swedish studies.[8]

Primary Surgery

None of the studies[18-32] demonstrated a survival advantage for a more extensive procedure (eg, mastectomy over breast-conserving surgery), although breast-conserving surgery was associated with a higher incidence of local recurrence (Appendix Table 4). This conclusion is not affected by the recent reanalysis of the National Surgical Adjuvant Breast and Bowel Project B-06 trial available from CancerNet through the Internet.[33] We reviewed four dimensions of postsurgical health-related quality of life[34-54] (fear of recurrence, psychological adjustment, body image, and sexuality) and found that, in most studies, patients undergoing breast-conserving surgery had a better body image than those undergoing the more extensive procedure. None of the other dimensions (particularly fear of recurrence) was affected by the type of surgery (Appendix Table 5).

Medicare allows $4166 (for the surgeon, anesthesiologist, and hospital) for the more extensive procedure and a total of $10 918 for breast-conserving therapy and radiation therapy ($3511 for breast-conserving surgery and $7407 for radiation therapy). Thus, the need for radiation therapy to prevent local recurrence increases the cost of breast-conserving surgery by $6752 over that of the more extensive procedure.

Adjuvant Therapy

We derived our conclusions about adjuvant therapy from the meta-analysis of the Early Breast Cancer Trialists' Collaborative Group,[55] which considered overall survival; insufficient data are available on the impact of this treatment on health-related quality of life. This meta-analysis concluded that adjuvant polychemotherapy for patients younger than 50 years reduced relative mortality by 25%; adjuvant polychemotherapy for those aged 50 years or more reduced relative mortality 12%, while tamoxifen for 2 years reduced relative mortality 20%; the two modalities combined reduced relative mortality 30% (Appendix Table 6).

To calculate expenses, we used the standard cyclophosphamide, methotrexate, and fluorouracil (CMF) regimen for chemotherapy. The charges for the nine treatments ($2523) include chemotherapy drugs, antiemetics, administration of these, supplies, blood cell counts, and physician visits. For women older than 50 years, we considered tamoxifen for 2 or 5 years or tamoxifen for 2 years with the addition of CMF polychemotherapy (Table 2). We did not add an extra charge for surveillance for endometrial cancer because that surveillance would be part of routine follow-up for all women who have a uterus.

Follow-up

To assess the effectiveness of routine follow-up testing for women with early disease, we used the recently completed Italian randomized clinical trials that compared intensive with routine surveillance[56,57] and other, less rigorous studies.[58-61] These studies have indicated that most recurrences, when detected, were symptomatic, and that routine follow-up testing did not improve survival

Table 2.—Charges and Benefits of Adjuvant Therapy for Women With Early Breast Cancer at Different Risks of Dying

Therapy	Compared With	Predicted Risk of Dying at 10 y, %*		
		20	40	60
	Women Younger Than 50 y			
CMF†				
Lives saved at 10 y/100 women treated	No treatment	5‡	10	15
No. to treat to save one life at 10 y		20	10	6.67
Charge to save one life at 10 y, $		50 460	25 230	16 828
	Women Aged 50 y or More			
Tamoxifen for 2 y				
Lives saved at 10 y/100 women treated	No treatment	4‡	8	12
No. to treat to save one life		25	12.5	8.33
Charge to save one life, $		50 000	25 000	16 667
Tamoxifen for 5 y§				
Additional lives saved at 10 y/100 women treated	Tamoxifen for 2 y	1	2	3
Additional No. to treat to save one life		100	50	33.3
Additional charge to save one life, $		300 000	150 000	100 000
CMF and tamoxifen				
Additional lives saved at 10 y/100 women treated	Tamoxifen for 2 y	2	4	6
Additional No. to treat to save one life at 10 y		50	25	16.67
Additional charge to save one life, $		126 150	63 075	42 058

*Node-negative risks range from 10% to 40%; node-positive risks range from 30% to 60%.
†Cost for nine treatments, including drugs (cyclophosphamide, methotrexate, and fluorouracil [CMF]), antiemetics, supplies, blood counts, and office visits is $2523.
‡Average life prolongation for 45-year-old, 1.4 y ($1802/y of life); for 55-year-old, 1.08 y ($1852/y); for 65-year-old, 0.79 y ($2877/y); and for 75-year-old, 0.55 y ($3636/y).
§Assumed 5% increase in benefit over tamoxifen for 2 y.

Table 3.—Charges and Benefits of Screening Mammography in a Hypothetical Health Care Organization of 500 000*

Age, y	No. of Women† (Package, Screens/y)	Annual Charges for Screen Package, $1000	Annual Benefit, No. of Lives Saved ‡	Charges per Life Saved at 10 y for Package of Screens, $	Annual Charge if Mammography Performed, $1000	
					Annually	Biennially
40-49	33 017 (4/7)	1670	0 (1.1)	(1480 000)	2922	1461
50-59	22 607 (3/6)	1000	5.5	182 000	2001	1000
60-69	22 128 (3/6)	979	6.7	146 000	1958	979
70-74	9323 (2/3)	550	0	...	825	413
75-79	7513 (2/3)	443	No data	Not evaluable	665	332
80-84	5202 (2/3)	307	No data	Not evaluable	460	230
Total	**99 790**	**4949**	**12.2** (13)	**406 000 (381 000)**	**8831**	**4415**

*Represents a cross-section of US population.
†Proportion in age group, 1991 US Census estimate.
‡Numbers in parentheses reflect sensitivity analysis if mammography reduced mortality 13%.[7]

nor did it seem to influence health-related quality of life (Appendix Table 7).

Routine surveillance, which includes office visits ($35) four times per year and screening mammography yearly, would incur charges of around $228 per year. Charges for a more intensive approach that would add an annual bone scan ($263), liver echogram ($94), chest radiograph ($38), and routine blood tests ($17) would be at least $640 per year. We have not included additional charges for evaluating false-positive results because recent data to estimate them are not available.

Model Health Care Organization

Benefits and charges for detecting and treating early breast cancer in a hypothetical health care organization with an enrolled population of 500 000 are presented. In this population, which represents a cross section of the US population, 360 new cases of breast cancer would be expected each year. Of these, approximately 83.5% or 300 would be stage I or II infiltrating carcinoma.[82]

RESULTS

Decision 1—Who Should Be Screened?

If we use the concept of a package of several screens as detailed by Tabar et al,[10] we estimate it would cost the health plan $11.9 million over 6 years to screen 50- to 69-year-old women (three screens each over 6 years); this screening would save 73 lives at 10 years (Table 3). Screening all women between ages 40 to 49 years (four screens over 7 years) would add an additional expense of $11.7 million over 7 years. The literature indicates that in this younger group, no lives would be saved; however, our sensitivity analysis, based on the Swedish overview[8] finding of a nonsignificant 13% reduction in mortality, indicates that eight additional lives might be saved over 7 years. Screening women aged between 70 and 74 years might add 1.8 days of life to each woman screened at an extra cost of $1.6 million over 3 years, but does not increase their survival at 10 years. No benefit data exist for women older than 74 years, but the rapid drop-off in benefit after 70 years of age suggests this group would benefit little from screening mammography.

Unfortunately, we cannot accurately apply the benefits found by the mammography screening trials to the present practice of continued annual or biennial screening because the trials were limited to a few years. However, we can conservatively estimate that continued biennial screening would provide no greater benefit for the equivalent number of screens than the benefit provided by the studies. The annual cost of repeated screening in the health care organization would be $8.8 million to screen all women older than 40 years annually and $4.4 million to screen them biennially. This cost would be reduced to $2

Table 4.—Charges and Benefits of Adjuvant Therapy of Early Breast Cancer in Women Younger Than 50 Years in a Hypothetical Health Care Organization of 500 000*

	Node-Negative Women (n=50)	Node-Positive Women (n=25)
Expected 10-y mortality, % (No. of deaths)	10-40 (5-20)	30-60 (7.5-15)
Treatment†	CMF	CMF
Benefit, %‡	25	25
Lives saved at 10 y, No. (mean§)	1-4 (2.5)	2-3.5 (2.75)
Charges to treat all patients, $	126 150	63 075
Charge to save one life at 10 y, $	50 000	23 000

*Of the 300 patients with local or regional disease (see Table 3), 25% (or 75) will be younger than 50 years of age (American Cancer Society National Cancer Database). Data from the Surveillance, Epidemiology, and End-Results (SEER) Program of the National Cancer Institute[85] show twice as many of these women will have local (node-negative) vs regional (node-positive) breast cancer.

†CMF indicates cyclophosphamide, methotrexate, and fluorouracil.

‡Proportional reduction in mortality.

§Mean of lives saved, calculated to estimate charge to save one life at 10 y.

million by screening women aged 50 to 69 years (the group that benefits most) biennially (the frequency in most of the studies).

Decision 2—What Kind of Primary Surgery?

The more extensive procedure and breast-conserving surgery followed by radiation therapy provide equal survival, but breast-conserving surgery would cost the health plan an additional $2.03 million because of the radiation therapy (300 people at $6752 per person; this extra cost assumes that reconstruction therapy is not part of the basic benefit plan). No increased mortality has been found with breast-conserving surgery without radiation therapy, but the health care organization could not consider withholding radiation therapy until studies have been performed on the effect of the increased local recurrence on health-related quality of life.

This latter point applies to women of all ages. In the several studies that have tried to treat women older than 70 years with tamoxifen alone, local progression mandated surgery in a large proportion of these women (Appendix Table 4). Two editorials have criticized this practice[83,84] and argued that elderly women should be treated the same as their younger counterparts.

Decision 3—Who Gets What Type of Adjuvant Therapy?

For most women younger than 50 years, polychemotherapy is the standard treatment because it reduces mortality by 25% (Table 4). Its benefit is greatest in those with the greatest risk of dying (patients with positive lymph nodes). Although there are data to determine the approximate number of women with local (node-negative) vs regional (node-positive) breast cancer,[85] data to determine which node-negative women, who generally have a lower risk of dying from breast cancer, will benefit from therapy are not available.[86] The health care plan's cost of treating all women younger than 50 years with node-negative breast cancer is $126 150; the cost for treating all node-positive women younger than 50 years is $63 075.

For women aged 50 years or more, treatment options are more complex (Table 5). The meta-analysis of adjuvant therapy showed benefit both for CMF polychemotherapy and for tamoxifen and consistently indicated that more is better. Five years of tamoxifen appeared slightly better than 2 years, and adding CMF polychemotherapy to tamoxifen further reduced mortality. For the 75 node-positive women, this translated into costs ranging from $150 000 for the simplest therapy to $564 000 for the most extensive. Because there are twice as many node-negative patients, these charges are doubled for these women. An added cost in tamoxifen-treated patients would be that of treating any endometrial cancers that would arise at a rate of 1.7 per 1000 treated patients. On the other hand, tamoxifen therapy in the United States will become cheaper once its patent expires.

Decision 4—How to Follow-up Patients After Treatment? (Appendix Table 8)

Routine follow-up testing incurs significant excess costs for the health care plan over clinical follow-up ($961 000 vs $343 000 over 5 years) and provides no benefit in survival or health-related quality of life.

Summary Decision Table and Basic Benefit Plan

Table 6 summarizes the possible options for treating breast cancer in this hypothetical health care organization. The basic plan for early breast cancer would include the following: (1) screening mammography only for women aged 50 to 69 years, (2) choice of surgery with radiation therapy provided for those undergoing breast-conserving surgery, (3) adjuvant therapy for all women at risk of recurrence, and (4) clinical follow-up without routine testing for metastatic disease. This would provide near maximum benefits for women to detect and treat this disease.

COMMENT

In this article, we have used cost-benefit analyses to design a basic benefit package to detect and treat early breast cancer for a health plan of 500 000 persons. One limitation was our inability to measure costs, but we feel that Medicare charges are a reasonable approximation. We have been able to express these charges in terms of their health impact and have benefited by the high quality of clinical breast cancer studies.

Screening Mammography

Screening mammography has been shown to reduce mortality from breast cancer. Unfortunately, this benefit is expensive. This is particularly true for women younger or older than 50 to 69 years. Women older than 69 years do not benefit much because of competing causes of death. The question of whether women aged 40 to 49 years benefit from mammography is controversial. The Canadian study,[14] which has been highly criticized,[87] is the only study that specifically evaluated this age group and it found no benefit. The Swedish overview,[8] which excluded the Canadian study, found a small but not statistically significant benefit for screened women. Our sensitivity analysis determined that obtaining this possible benefit is expensive. Furthermore, the meta-analysis by Elwood et al,[7] which included the Canadian study, found no benefit for women aged 40 to 49 years, and the validity of the Canadian study has been vigorously defended by Baines.[88] The recent international workshop[89] upheld this viewpoint as did the most recent update from Nijmegen, the Netherlands[90] which also failed to demonstrate a benefit for younger women.

Therefore, if a plan were to adopt a cost-effective package, it would restrict mammography to biennial screens for women aged 50 to 69 years. This would save a health care organization of 500 000 approximately $2.4 million compared with screening this group annually and up to $6.8 million compared with screening other age groups. The national saving could be $1 to $3 billion, depending on compliance, for the same restrictions. If a plan adopted this strategy with regard to women aged 40 to 49 years, it would have the support of the National Cancer Institute, which has changed its screening recommendations and now recommends screening only women older than 50 years,[91] but not of the American Cancer Society, which still recom-

Table 5.—Charges and Benefits of Adjuvant Therapy for Women Older Than 50 Years With Early Breast Cancer in a Hypothetical Health Care Organization of 500 000*

	Treatment for Node-Negative Women (n=150)†				Treatment for Node-Positive Women (n=75)‡			
	Tamoxifen for 2 y		Tamoxifen for 5 y		Tamoxifen for 2 y		Tamoxifen for 5 y	
	And No CMF vs No Treatment	And CMF vs No CMF	And No CMF vs Tamoxifen for 2 y	And CMF vs No CMF	And No CMF vs No Treatment	And CMF vs No CMF	And No CMF vs Tamoxifen for 2 y	And CMF vs No CMF
Additional benefit, %§	20	10	5	10	20	10	5	10
Additional lives saved at 10 y, No. (mean)	3-12 (7.5)	1.5-6 (3.75)	1-3 (2)	1.5-6 (3.75)	4-9 (6.8)	2-5 (3.4)	1-3 (1.7)	2-5 (3.4)
Additional charges to treat all patients, $	300 000	378 450	450 000	378 450	150 000	189 225	225 000	189 225
Additional charge per life saved at 10 y, $	40 000	101 000	225 000	101 000	22 000	56 000	132 000	56 000

*Of the 300 patients with local or regional disease, 225 will be age 50 y or older and two thirds of those will be node-negative. Tamoxifen charges are at $1000/y. CMF indicates cyclophosphamide, methotrexate, and fluorouracil, and charges are at $2523.
†Expected 10-y mortality, 10% to 40% (15 to 60 deaths).
‡Expected 10-y mortality, 30% to 60% (22 to 45 deaths).
§Proportional reduction in mortality.

Table 6.—Summary of Charges and Benefits for Screening for and Treatment of Early Breast Cancer in a Hypothetical Health Care Organization of 500 000

Procedure	Annual Benefit, No. of Lives Saved (Mean)*	Annual Charge, $1000	Annual Charge per Life Saved at 10 y, $
Mammography screen			
50-69 y	11.9	3959/1979†	166 302+‡
40-49 y	0 [1.1]§	2922/1461†	[1 480 000]‡§
70-74 y	0	825/413†	...
Primary treatment			
Breast-conserving surgery and radiation therapy	Better body image	3284	Not applicable
More extensive procedure	Radiation therapy not needed	1250	Not applicable
Adjuvant therapy for women aged <50 y			
Node-positive, CMF‖ treatment	2-3.5 (2.75)	63	23 000
Node-negative, CMF treatment	1-4 (2.5)	126	50 000
Adjuvant therapy for women aged ≥50 y			
Node-positive			
Tamoxifen for 2 y	4-9 (6.8)	150	22 000
Tamoxifen for 2 y and CMF	2-5 (3.4)	189¶	56 000¶
Tamoxifen for 5 y	1-3 (1.7)	225#	132 000#
Tamoxifen for 5 y and CMF	2-5 (3.4)	189¶	56 000¶
Node-negative			
Tamoxifen for 2 y	3-12 (7.5)	300	40 000
Tamoxifen for 2 y and CMF	1.5-6 (3.75)	378¶	101 000¶
Tamoxifen for 5 y	1-3 (2)	450#	225 000#
Tamoxifen for 5 y and CMF	1.5-6 (3.75)	378¶	101 000¶
Follow-up over 5 y			
Clinical		69	Not applicable
Clinical and routine testing	None found vs clinical	192	Not applicable

*Variation due to differing mortality risks.
†Annual/biennial screening.
‡Based on charges for package divided by number of years needed to provide package.
§Numbers in brackets indicate sensitivity analysis of nonstatistically significant mortality reduction of 13%.[7]
‖CMF indicates cyclophosphamide, methotrexate, and fluorouracil polychemotherapy.
¶Additional charges compared with the procedure in the previous row and charges for lives saved are marginal charges compared with previous procedure (see Table 5).
#Additional charges compared with tamoxifen for 2 y. Charges for lives saved are marginal charges compared with tamoxifen for 2 y.

mends screening for all women older than 40 years.[32]

Primary Surgery

The type of surgery does not affect survival. Breast-conserving surgery is as effective as more extensive surgery. What is important is the ability to prevent local recurrence and satisfy the patient. While more extensive surgery will provide the lowest local recurrence rate and be the choice of some women, we have seen from the studies of health-related quality of life that others will suffer from loss of body image. Although it has been thought that the loss of body image with extensive surgery is compensated by a reduced fear of recurrence, our review of the studies in the literature reveals this presumption to be wrong.

Preventing the loss of body image costs more because breast-conserving surgery requires the addition of radiation therapy to prevent local recurrence. This would add an extra $2 million to our hypothetical health care organization's expenses annually and cost about $1 billion more nationally. However, it would be inappropriate to eliminate radiation therapy unless there were data on the effect of the certain increase in local recurrence on health-related quality of life. This is an area that needs further clinical research to identify which patients are at risk of recurrence and thus in need of radiation therapy.

Adjuvant Therapy

Adjuvant therapy benefits everyone who receives it. This benefit is directly proportional to the patient's risk of recurrence. Even treatment of low-risk patients benefits them, but this is relatively expensive in terms of the charges for saving or prolonging a life compared with treating high-risk patients. But the benefit-to-cost ratio of adjuvant therapy is greater than that for screening mammography. Likewise, the benefit of adding CMF polychemotherapy to tamoxifen in women older than 50 years adds expense, but again this expenditure achieves more value than screening mammography in this age group. The total expense for our hypothetical health care organization for treating all patients with the most aggressive adjuvant therapy would lead to charges of more than $2 million. Treating only node-positive patients with the least aggressive adjuvant therapy would incur charges of around $200 000.

Follow-up

Routine follow-up testing after primary treatment for early breast cancer

provides no known benefit in terms of survival or quality of life. Thus, our health plan should offer no more than clinical examinations, without testing, at intervals of 3 months to 1 year. Whether even this is required has not been evaluated, nor is it known whether specialists are needed for this follow-up.

Limitations

Our mammography analysis cannot measure the benefits of long-term mammography because all the studies were restricted to a few years. We also were unable to evaluate, with the exception of surgical treatment, the psychosocial outcomes of other therapeutic decisions. Even the toxicities and impairment of health-related quality of life during adjuvant therapy have not been well studied. For example, for women older than 50 years, CMF polychemotherapy added to 2 years of tamoxifen is more effective than 3 extra years of tamoxifen, yet one would need more information on the added toxicity of CMF polychemotherapy in this age group before recommending it routinely. Research is needed here to help physicians and patients make better decisions.

Our study also suffers because we cannot measure the true costs of treatment, both to the patient as well as to the health care organization. We have used Medicare charges in Southern California, which are useful for the purposes of internal comparison but are not necessarily generalizable to the rest of the United States or the world. Furthermore, we have not been able to estimate the patient cost in terms of toxicity from chemotherapy and time lost from work or from participating in one's major activity.

Finally, we also falter when it comes to measuring the benefit of treatment. Neither the concept of a life saved at 10 years nor the average prolongation of life can describe what truly occurs with treatment. The inexorable downward slope of the survival curves published in the adjuvant trials show that a life saved at 10 years may be lost at the 11th year. Likewise, the concept of average life prolongation does not take into account winners and losers in the fight against breast cancer. Furthermore, its estimation is subject to major variation in published reports.

Conclusion

We have discussed various decision points in the management of early breast cancer to illustrate a pragmatic approach to the initial definition of a basic benefit package. The advantage of the evidence-only approach is that it allows readers to judge the merits of our argument much more readily than they can judge the pronouncements of panels of experts or consensus conferences. This ability to evaluate our arguments becomes important because we have directed our study not only at individual physicians but at health care organizations who may be providing a benefit package for a large number of subscribers.

With the information we have presented, a health care provider can make choices. For example, providing aggressive adjuvant therapy, although less appealing, is a more cost-effective procedure than screening mammography. It is unclear whether any follow-up care other than routine primary care is needed after treatment of early breast cancer.

Finally, we would emphasize that this kind of analysis can be applied to many diseases and that this application may lead to the better choice of therapies for these diseases. We were fortunate in that breast cancer has been well studied with regard to outcomes such as survival and relatively well studied with regard to quality of life. Such is not the case with many other diseases. Perhaps analyses such as ours will encourage the performance of more and better clinical studies that will adequately measure these endpoints.

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HEALTH SCIENCES PROGRAM REPRINTS

Reprint Number	Title and Author
	1995
RP-368	The Importance of Physician Communication on Breast Cancer Screening of Older Women. S. A. Fox, A. L. Siu, J. A. Stein.
RP-369	Screening Mammography and Older Hispanic Women. S. A. Fox, A. L. Siu, J. A. Stein.
RP-370	How Can Care for Depression Become More Cost-Effective. R. Sturm, K. B. Wells.
RP-372	Clinician Specialty and Treatment Style for Depressed Outpatients with and Without Medical Comorbidities. L. S. Meredith, K. B. Wells, P. Camp.
RP-374	The Chiropractir Satisfaction Questionnaire. I. D. Coulter, R. D. Hays, C. D. Danielson.
RP-375	Do Response Options Influence Self-Reports of Alcohol User? R. D. Hays, R. M. Bell, T. Damush, et al.
RP-387	Functioning and Well-Being Out comes of Patients with Depression Compareed with Chronic General Medical Illnesses. R. D. Hays., K. B. Wells, C. D. Sherbourne, et al.
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RP-269	The Appropriateness of the Use of Cardiovascular Procedures. S. J. Bernstein, J. Kosecoff, D. Gray, et al.
RP-272	Analytic Difficulties in Applying Quality of Life Outcomes to Clinical Trials of Therapy for HIV Disease. S. H. Bozzette, N. Duan, S. H. Berry, et al.
RP-334	A Perceived Health Index for Use in Persons with Advanced HIV Disdease: Derivation, Reliability and Validity. S. H. Bozzette, R.D. Hays, S..H. Berry, et al.
RP-281	Contributions of Case Mix and Intensity Change to Hospital Cost Increases. T. B. Bradley, G. F. Kominski.
RP-270	Health Care Reform Is on the Way: Do We Want to Compete on Quality? R. H. Brook.
RP-261	Physicians' Characteristics Influence Patients' Adherence to Medical Treatment: Results from the Medical Outcomes Study. M. R. DiMatteo, C. D. Sherbourne, R. D.Hays, et al.
RP-308	The Impact of Response Options and Location in a Microcomputer Interview on Drinking Drivers' Alcohol Use Self-Reports. R.D. Hays, R.M. Bell, L. Hill, et al.
RP-323	Four-Year Cross-Lagged Associations Between Physical and Mental Health in the Medical Outcomes Study, R.D. Hays, G.N. Marshall, E.Y.I. Wang, C.D. Sherbourne.

RP-339 The Impact of Patient Adherence on Health Outcomes for Patients with Chronic Disease in the Medical Outcomes Study. R.D. Hays, R. L. Kravitz, R.M. Mazel, et al.

RP-365 Development of the Kidney Disease Quality of Life (KDQOL) Instrument. R. D. Hays, J. D. Kallich, D. L. Mapes, et al.

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RP-164 Insurance Coverage for Drug Abuse. J. A. Rogowski, D. E. Kanouse, R. H. Brook.

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Mrs. JOHNSON. What about the less specific prevention approaches? It is one thing for procedures in breast cancer and colon cancer and things like that. How about annual physicals and early physician visits or early nonphysician consultations? Some of the less specific approaches to prevention.

Ms. PALMER. In my view, when we are talking about proven health promotion strategies and health prevention strategies, that is, we have good scientific evidence that these strategies work to improve patients' health in the long run, to detect disease or prevent disease, the best approach actually is to ask patients themselves, that is, to use survey techniques, where we learn from the patients whether they were counseled, and whether they understood the counseling they received.

For instance, again, for smoking, about appropriate diet, about lifestyle, exercise, and about screening, they should receive. That is the most direct approach. Failing that, we can turn to data that come from medical records or from administrative data systems, and learn whether proven strategies for health promotion and disease prevention were being used by a managed care plan or a fee-for-service plan.

Mrs. JOHNSON. Have you been able to look at all at what the consequences are of integrated systems of care versus the self-referral system of the past? Have you been able to test and look at what is the impact on health and cost of a system that is capable of receiving early concerns, not necessarily a doctor's visit, and is able to manage concerns constructively through a more integrated system of care?

Dr. BROOK. I guess the bottom line to that question is that we have too little information that has compared fee-for-service systems with managed care. One challenge is that there are very different kinds of managed care organizations. We cannot compare a monolithic managed care concept versus a monolithic fee-for-service concept. There really needs to be more work done than what has been. Up to now what we have found—and a lot of our research has been done in the younger population—that on average, the quality of care delivered and the health status of the population is in the fee-for-service system compared to the managed care system is about the same. That is a very broad summary.

Now, we have very little information about the new forms of managed care that have sprung up over the last 10 years. Most of the information we have is about the group or staff models of managed care. They are the more traditional models and have been around for a longer period of time.

Dr. DETMER. I would say the pace with which change is occurring in the definition or redefinition of managed care is such that unless you have tools that can manage these things over time, you have got to be very cautious about generalized statements.

Mrs. JOHNSON. I thank you for your comments. I do think that as hard as it is right now to develop outcomes research and guidelines and all those things, this is the easy part, that because it is more procedure specific, it is more disease recovery specific, and that what we need to get to is systems impact information.

I thank you for your comments. My time has expired.

Chairman THOMAS. Mr. Ensign will inquire.

Mr. ENSIGN. Thank you, Mr. Chairman.

I too have a lot of questions raised by this panel. Dr. Palmer, you mentioned the consumer type reports that allow consumers to make a better choice on their own. Granted when you are looking at large companies deciding what kind of health plan that they are going to choose, they may be able to have the experts to look through those consumer reports.

Do you really think that as complex as medicine is, it is not a question of looking at this like a safety record for an automobile that Consumer Reports may put out now, but with the complexities of medicine and choosing doctors, because there is a lot more bedside manner that goes into choosing doctors, if you are looking at how a consumer is going to make that choice, there are so many variables that go into that. Are these consumer reports going to be too complex so that people are not going to read them in the first place, because their is too much information?

Ms. PALMER. My guess is that consumer reports for health care will be like Consumer Reports for buying automobiles and expensive electronic goods and so on. There will be people who use them and people who are unable to use them.

I think that consumer reports in health care need to be a great deal more detailed than the kinds of report cards we have been seeing to date. That is, I could picture that if I have diabetes, I know that I have a risk for my family of breast cancer, I know that my husband is at risk for heart attack, when we go shopping for our health care plan, as we become Medicare beneficiaries, we would like to know how well do the plans take care of those conditions, and in addition, in relation to Congresswoman Johnson's concern, how well do they provide preventive care.

I think that there are many Medicare beneficiaries who would use that information and could benefit from it. But it is clearly not enough, as you point out. There are people who will not be able to understand or use that information—

Mr. ENSIGN. The reason I bring up the question is, there is a tiny percentage of the population that will use those reports, compared to the amount of money it is going to cost to compile those reports.

Dr. BROOK. The bottom line from economics and other fields is that, if only 10-percent of the population actually use them and made choices that were more rational, that would change the characteristics of the marketplace. We do not need 90-percent of the population to do that.

Mr. ENSIGN. I am not saying that we do, but will we even get 10-percent.

Dr. BROOK. I would love to be able to come back to you 5 years from now and answer that question for you with data instead of opinion.

Mr. ENSIGN. Dr. Brook, you tossed out $600 million for one figure and $10 per every American, about $2.6 billion. Where do you come up with those numbers?

Dr. BROOK. Basically we have looked at how much it costs to produce guidelines and standards. We have worked with managed care plans and businesses to develop a set of quality tools that would be used and continuously improved upon. Based on our experience, this is the range of money.

Mr. ENSIGN. Managed care does that now?

Dr. BROOK. No. For instance, in the guideline development area, someone asked, how do you pick a guideline? The classic way that doctors have put guidelines together is over lunch and tuna fish sandwiches, and basically you come up with a guideline at the end of it. Then you say, it is a guideline.

The way the agency and respectable public agencies are doing this is to put information together so that when I send it out to a doctor, it is based on science. That is a million dollar activity. I am sorry, but we have that much information and it takes that much time to do it. If you start doing it, that is the numbers you come up with.

Mr. ENSIGN. Did you get this through government estimates?

Dr. BROOK. No.

Mr. ENSIGN. These are private sector—

Dr. BROOK. Absolutely.

Mr. ENSIGN. When you are looking at government doing something for the same price that private sector is doing it, I haven't seen that.

Dr. BROOK. The government role so far in this field has been to give people like myself the money to do that, to give people that work in universities and not-for-profit organizations the funding to conduct research.

For the sake of argument, why give the money? Let's say that I am less efficient than a for-profit person. However, I put all my products out in the public domain, everything I do goes in the public domain; Let's say I am 25 percent less efficient than somebody in a for-profit firm. I do not believe that, but let's say I am. The bottom line is that everyone gets the benefit from what I do. As long as the people that are funded by these agencies actually put this material out for everybody to use—every managed care plan, every hospital, every doctor—and make it freely available, then I do not see how the for-profit center can produce, as economically, the standards and tools to measure quality or the kind of information we have talked about.

In terms of policy change, what is the incentive in the for-profit sector to actually produce and give you the kind of information and answers to the questions you asked us? Who is basically going to provide the answers to whether market reform is actually working? It is not in the interest of the industry to answer that question. It is in the interest of the Federal Government in a public role to answer that question. But, it does require funds to do so.

Mr. ENSIGN. Thank you, Mr. Chairman.

Chairman THOMAS. At the very least, even if the information is not as efficient as a percentage dropoff, it is there for discussion. It is the center of discussion for criticism and praise, which creates an evolution onto another discussion.

Mr. Christensen.

Mr. CHRISTENSEN. Thank you, Mr. Chairman. I also want to thank the panel, and especially Dr. Brook, for coming all the way from California and testifying here this morning.

I greatly appreciate your time and your in-depth knowledge of the issue. I have tried to review your written testimony as much and as quickly as I could. I probably would disagree with you on

most of your points, but I do want to throw it open for discussion and see if I can learn more on the issue.

The main question I have is, I have read through here and I see $250 million here and $2.5 billion here—where are we going to get this money from? Do you have any ideas for us from that point of view?

Dr. BROOK. Well, I am not in your chair, so, I cannot say where it should come from.

Mr. CHRISTENSEN. We have a real problem right now—

Dr. BROOK. Let me talk about the health system by itself. In my work on quality over the last 20 years, the marginal return in terms of health from investing the last dollar in the health system in this kind of work exceeds the marginal return in investing in actual service to a patient. We invest so little in our health system in dealing with these kinds of issues that there is more bang for the buck, so to speak, for investing in improving quality than there is in investing the last service we provide to people.

I am not here to tell you where to find the money, or to take it from Energy, or Defense, or somewhere else. The answer to your question is, you would get more in terms of health for the Medicare population by investing money in improving quality than in providing one more medical service to the population.

Mr. CHRISTENSEN. One of the things that we have been faced with on the Hill here is the fact that we are in a major budget crisis. Last week we fought tooth and nail to get a $17 billion cut. This week and next week we are going to be looking at $180 billion in various cuts to the growth of government.

I do not disagree with you that having the knowledge and the information before you is helpful. I guess I would be very questionable—I am one of those conservatives on the Hill that questions nearly everything government does and believes that maybe there is a better alternative and a better approach.

Do you believe that government could ensure quality by monitoring the hospitals and physicians on a case-by-case basis? Do you believe that the regulatory approach—

Dr. BROOK. Absolutely not. What I have tried to write in the paper, and I am sorry if it didn't come through, is that, I do believe in trying to make a competitive marketplace work, and that to function effectively every market needs to have information on quality and price. The role of the Federal Government is to actually stimulate the market to function well in terms of both quality and price.

That is what that investment would buy. If I was going to give you a number for regulating quality of care on a case-by-case basis, that number that I gave you would be many times higher.

I am not proposing a regulatory approach. I would just like the health care market to work well so that when you and I get older, maybe we will have a chance of going to doctors who produce better quality of care. That is, I feel there is a need to make the market fair. That is all I am asking, is for the Federal Government to make sure the market is fair i.e., that it competes in quality and price. Part of that is investment in science in this field.

Mr. CHRISTENSEN. What would be your opinion on how we could go about getting a sampling of some of this information through

the private sector? I realize what you are saying is that it is very tough for us to encourage the hospitals to work together and the various managed care organizations to give us this information on a voluntary basis so that we could assimilate some data without mandating that they do so.

There has got to be a way we can do this through the private sector. I know you have put a lot of time and effort into this. I would like to sit down and visit with you, because obviously you have a lot of knowledge in this area. I just don't know that the government approach is the best way to go about it.

Dr. BROOK. If I gave you the idea that institutions in the private sector will not cooperate, I didn't mean to say that. Managed care organizations and hospitals will help in this. One of your next speakers is Gail Warden and he has worked cooperatively with us in the past.

Once the tools are out there in the public domain, it may very well be that the for-profit secter is the best way of actually measuring and disseminating the information to the American public, and maybe the government doesn't need to play as great a role as it played in the past. The actual science, because of the whole marketplace problem, is probably a place where the government really needs to put a serious investment.

I am confident the private sector will come along if indeed the tools and the science were there to make it easy for them to come along.

Mr. CHRISTENSEN. Thank you, Dr. Brook.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you.

Dr. Brook, you indicated in your opening comments you have been doing this for more than 20 years. My assumption is that things have begun to happen which allow you to do it better, more efficiently, better understanding.

Have we got some breakthroughs or has it been this slow accumulation and do we now have inertia moving us forward?

Dr. BROOK. There has not been a great deal of funding over the last 20 years, but there have been some breakthroughs. We can measure health. If I had to testify before you 20 years ago, I would not have had the foggiest idea what tools would be available to measure health. We have also done work to measure the appropriateness of care. I can come to you and tell you that a large part of Medicare dollars are wasted based on research; and I can tell you a large number of people do not get the care they need, based on tools developed by public funds provided to both HCFA and the AHCPR.

There have been major breakthroughs in the methods and the tools. It is now time to expand upon those, to develop practical, feasible tools and put them in place so that they can be used. It is time to go out of the R&D laboratory into an expanded science role so that these things can actually be used to help make the marketplace work better.

Chairman THOMAS. There is a local clothing retailer whose slogan is, "An educated consumer is our best customer." Dr. Detmer, your outline of what people need to know is, I think, something

that we can probably all agree upon, except the individual who is supposed to know it.

You have outlined a fairly heavy responsibility in terms of knowledge. It is a little bit like the American Association of Political Scientists who want to talk about the issues-oriented campaign versus the thing that really does motivate people to vote for a candidate, and they are always frustrated that people do not do that.

We have an ignorant consumer today in large part based upon the structures. Your model is obviously one we would like to strive for, but going back to the Consumer Reports example, they take quality and cost and wind up with a check rated best buy product. I think we are probably going to have to shoot for some structure, which I said to the earlier panel, that has either some legitimacy or respect, that does a lot of that internal evaluating along all those criteria, that we have to have, but comes out the other end with a recommended buy, a ranking, minimum approval structures.

I guess my question is, isn't this probably inevitably, unfortunately, a public agency rather than private? I tried to put as many adjectives as I could. Can you conceive of a private structure that could attain that kind of prestige for rating purposes?

Dr. DETMER. I guess where I come from, and I think Dr. Brook and I roughly feel the same on this, we need a scientific framework so that at least report cards have validity and are based on reliable information. Given that, I think the private sector can in fact score itself, but you probably do need to have somebody riding herd on that, although it is not as though we live in a society that does not look over each other's shoulder.

There clearly has to be a public role, without a doubt, to set some of the standards, and I think even the private sector is asking for that. But beyond that, I would have to really candidly say to you, I think we are still a little early in this. We have made a lot of progress in the measurement tools of the care itself in this business of how to transmit information to buyers in a way that can really help them make their decisions.

Some information needs may be specific to one's particular problem. If you need your hip replaced, you want a specific hip replacement data and not necessarily generic information. I do want to loop back to a comment, though, to Mr. Ensign. I think his question relates to the fact that if we do have public report cards, let's not forget that we are talking about a competitive marketplace where people, systems compete against one another. The systems also read those report cards a lot.

It is not as though the only check and balance in this is the user, the consumer, the beneficiary seeking it. The people out there in the market trying to deliver value pay a lot of attention to that themselves because they know they are also in competition with one another. Sometimes that can get lost sight of.

Chairman THOMAS. My concern is we move away from focusing on what we should not be doing to what we should be doing. We have a tendency with government agencies to make choices for people because you can make a better choice than they can. Cars were mentioned earlier, that people choose cars by color. That, to me, is an unbelievable method of choice, but a lot of people do that.

If you have that public agency, my fear is that you are going to get an unfortunate standardization, a lag time for making positive changes, because right now we are being saved in the health care sector by the private sector changing as rapidly as only the private sector can change and to the degree you do lock it into the government.

Now, my concern is, how do we, as we move forward—and you indicate perhaps the time line for getting these measurement tools is not as soon as we had hoped. To me, five, seven years is very disappointing, not coming up with something—

Dr. DETMER. I think there will be things coming sooner than that. I do not want to give the sense that we are not working on this and that it will not continue to evolve.

Chairman THOMAS. Easy things will come first and then the harder things.

Dr. DETMER. I do not think the government should be the only one prescribing these things. I do think it needs to set some compass points. We need to know when we say "government" what that means. We need to know where "south" is and "east" and "west". Unless we set those degree of standards, so we know what is A compared to B, do you really know that the report card is anything other than something in the wind?

Chairman THOMAS. I understand compass points. I understand relative relationships, "good" versus "better." I understand "best" less. What inevitably is going to happen is that people will use this and it will be converted into marketing tools. People will take these various standards and advertise, perhaps not using the ones that someone else on an objective hierarchal ranking would place as the most important, and that is part of my fear, of getting in and indicating that this particular choice is more important than another.

Going back once again to products in the marketplace, I know everybody who would look at it and test in all the magazines said the beta system was a far better way for video recording. VHS blew them out of the market, in part on pure price and availability.

It is not always the quality aspect. My concern is that you are going to slow down the process of change if we get into a government structure of picking what is, quote, unquote, best.

Dr. BROOK. Having come from southern California and having just studied most of the companies that provide managed care to about 4 million Californians now in individual group practices through all these new models, the innovation that has occurred in managed care is how to manage the price of care.

We have gatekeepers now. I, as a professor of medicine at UCLA, cannot refer my for-profit patients to a dermatologist without a Committee of my own doctors approving it. We have struggled very hard to make sure that costs can be contained. There has been much less innovation on the quality side.

Even though we are concerned that we may have iatrogenic and bad side effects from measuring quality, I am fearful that if we do not try to keep this market fair in both quality and price, the price is going to drive the issue.

Even though there are lots of good doctors and hospitals and managed care companies, if the lowest price drives the marketplace

and you cannot distinguish a better product from a worse product, we are going to be in a lot of trouble in the marketplace.

The Federal role has got to be to put the science out there and allow the marketplace to compete both on quality and price equally.

Chairman THOMAS. If there is a yardstick, people can compare if they have a desire to compare.

Dr. Palmer?

Ms. PALMER. Mr. Chairman, for all the reasons you have described, I don't think that consumer reports and consumer choice are sufficient means to protect the average citizen, including particularly the Medicare beneficiary, in terms of quality of care. That is why I believe that some kind of cooperative quality improvement program is needed, something that does the kind of brokering that the Federal Aviation Administration does on safety.

I think that is an essential component. There is too much that ordinary people will not be able to follow or have the interest to follow because they do not expect to get sick, just as one does not expect one's airplane to crash.

That is why some additional effort, which is brokered by a neutral party that is not in the market, namely some government structure, maybe is essential.

Chairman THOMAS. The only concern I would have is that one of the reasons everybody hangs together is that there are alternate forms of transportation, and that it is important to make sure that people feel comfortable about flying because they could take another route.

My concern is that we have only one route on health care, unlike the diversity structure.

Does the gentlewoman from Connecticut have another question?

Mrs. JOHNSON. Thank you, Mr. Chairman.

This is such an important area and so difficult to understand yet so important to our future that I just want to add a comment.

Dr. Detmer, in your testimony, you point to some things that I know from years ago, introducing legislation that would try to develop uniform data sets. I recognize a lot of what you are saying and trying to do, but at the same time you raise all the red flags.

You say, "Only computer-based patient record systems will allow us to monitor care continuously, automatically issue appropriate reminders, provide rapid access to clinical practice guidelines relevant to the case at hand, and take actions to assure better outcomes."

Now, to me, that is not our goal. I do not want a system where someone is monitoring care outside of that physician, on that moment-by-moment basis, and automatically issuing appropriate reminders that may be irrelevant to this specific patient. It may not show up in the data but it may show up in the communication between physician and patient, provide rapid access to clinical practice guidelines which are, by definition, average or general and not specific.

One of my fears in this area is that as we develop practice guidelines, we will come to believe in them, and as much as they are useful and as important as they are, they in the end are no

substitute for the judgment of the physician as to the care for a specific patient under specific circumstances.

I am interested, and I think Dr. Palmer to some extent has focused on this, what do we need now, what are the tools that we can best develop now serving consumer information as one of them, and what are the things we should be moving toward, which is the definition of certain common denominators or data that we want to develop in a uniform way to give us insight into both outcomes research in the sense of procedural specific or treatment specific information, quality information, and then systems specific information.

I think we have to be a little cautious about whether even if it is going to be desirable to develop automated patient records to the extent that you are recommending them, because one-time data entry by health care professionals, does that mean the doctor talks to someone who does the data entry, does that mean the doctor does the data entry? How do we get this accurately? How many miles can it go through and what kind of overhead are we going to put in there?

How much should be retrievable? How do we dump the right stuff into a national research effort on outcomes? And how do we not? If we dump information into a national research effort, how do we accommodate it with the fact that this hospital takes only very, very serious cases and, therefore, of course, has a higher complication rate?

I guess I am worried about the extent to which this panel wants to press us forward on the uniform systemic change matter. I am more interested in what are the three key things we should do right now to assure that as we move public programs into private sector alternatives, and States are doing this in Medicaid all the time now, there is a lot going on, what are the things we can do that will give us the best quality oversight of change.

Dr. DETMER. I probably would like to chat with you at another time, because I think actually you have highlighted almost every relevant downside. There are legitimate downside risks but there are also upside gains that I think could get a legitimate response. Obviously I will not do that at this point, but I would like to, because I think there are clear things to gain from them.

But to get to your specific question, I think that, as I mentioned, the bipartisan effort last year on the Health Information Modernization and Security Act is a needed piece of legislation, something quite like that. If I were to say one thing today, that would be where I would come down, because it is not as though we are not seeing these computer-based systems developing. I think that we do need to address that matter, because I am even more worried, candidly, about inheriting some of the downsides that you have spoken to in the absence of that kind of legislation than with it.

It doesn't quite get us immediately to more report card data, but it does secure some things we really need to attend to. I hope that is responsive.

Mrs. JOHNSON. That is helpful.

Dr. Palmer.

Ms. PALMER. If we have left you with the impression that there is nothing that can be done now, I think that is a big mistake.

Mrs. JOHNSON. You have not left me with that impression.

Ms. PALMER. I think there are some things that can happen that are happening immediately. Let me just mention one example. In the DEMPAQ project in which we studied care in three States for Medicare beneficiaries and fee-for-service office care, we were able to identify certain key aspects of diabetes care, including regular eye exams to detect early and prevent disease causing blindness, the use of tests which monitor much better control in diabetes. We know those things are not being received well enough by Medicare beneficiaries in fee-for-service care.

There is a similar measure in managed care plans. We know in some large managed care organizations that these things will also not be provided to Medicare beneficiaries. The answers to some of these problems lie, as you mentioned, in systems issues. The individual physician cannot turn around a system that makes it difficult to orchestrate the business of getting a proper eye exam done on a diabetic by a specialist and getting the patient back, or the monitoring of a diabetic over time.

Providing thrombolytic therapy promptly for a heart attack patient in the emergency room depends upon building a system of care which orchestrates how to do that. Just the physician making the decision isn't enough. We know these are areas in which already cooperative quality improvement programs are occurring in your own State of Connecticut. In the case of diabetes, you heard Dr. Vladeck testify earlier, that the measures of quality adapted from the DEMPAQ and HEDIS projects are soon going to be tested in managed care and already in fee-for-service care. The three PROs involved in the DEMPAQ study are beginning intervention campaigns, quality improvement programs in the three States, aimed at improving diabetes care.

We know how to start. We need to study how those efforts unfold, and what is the best way to do them. Over time, add in more disease modules, other conditions and preventive care, until we get a more complete program of how to maintain quality for Medicare beneficiaries.

Dr. BROOK. If I were to answer that question, I would come back to the statement, the world is changing extraordinarily rapidly out there in the private sector. Medicare is going to catch up. When that occurs, you want to make sure that that marketplace is functioning both on price and quality.

We can immediately begin both with improving the science and getting information out to everybody to make that happen, even if the first pass at it is not perfect. I am not worried that we are going to make mistakes in the information we release in the beginning. I believe 5 years from now it will be better than the information released next year. I believe we have to begin in a serious effort so the marketplace does not rely on price alone.

A lot of the people who are here after us are engaged in the private sector to produce great products or do great things. They need to have a marketplace out there to receive their goods. The role of the Federal Government has got to be to make sure that happens. That involves an investment in science, in getting information out.

That is where we have to start. If we are going to push to get places to have computerized medical systems or to want to do quality improvement, there has got to be external motivation to do it. People will buy better products and the better products will survive. The central role of the Federal Government must be to make information about quality available.

Chairman THOMAS. I want to thank this panel very much. Part of your problem in our anxiousness to find these tools to be able to utilize them is because, to a very great extent, we are dealing with art as well as science. The hierarchical culture of medicine in this country and the role of particular individuals within that culture have made it difficult in the past.

We are dealing with Medicare, which is kind of the last vestige of the old fee-for-service structure. We have got to convince people that they want to change. These kinds of measurements are critical for us in that process.

I want to thank the panel very much and look forward to the materials that you promised to send us.

Dr. DETMER. We are very grateful for your interest in this as well.

Chairman THOMAS. It is critical, and a tool that we need. We wanted to thank you once again for coming.

That was in part a transition to the next panel, which is Margaret E. O'Kane, president of the National Committee for Quality Assurance; Dennis S. O'Leary, president of the Joint Commission on Accreditation of Health Care Organizations; and David M. Bee, vice president of the American Medical Peer Review Association, to provide us with how rapidly the culture of medicine has changed.

We will start with Ms. O'Kane.

STATEMENT OF MARGARET E. O'KANE, PRESIDENT, NATIONAL COMMITTEE FOR QUALITY ASSURANCE

Ms. O'KANE. Good morning, Mr. Chairman.

Chairman THOMAS. I would caution you, these microphones do not pick up. They need to be talked directly into so we can hear everything you have to say.

Thank you very much.

Ms. O'KANE. Thank you. My name is Margaret O'Kane. I am president of the National Committee for Quality Assurance. As this Subcommittee examines the private sector's efforts to reduce the costs for health care, we commend the Chairman for convening this hearing to explore the equally important subject of private sector quality improvement initiatives.

NCQA is an independent nonprofit organization which oversees two complementary approaches to health care evaluation; accreditation and performance measurements. NCQA accreditation examines a health plan's infrastructure while clinical and service performance is measured through NCQA's health plan employer data and information set, HEDIS 2.0 and 2.5, which I think you have heard a couple of the speakers refer to this morning.

NCQA is governed by a board of directors which includes large purchasers, health plan representatives, a consumer representative, a State legislator, a union representative, and AMA represent-

ative, and independent quality experts. By the end of this year, we will have accredited over half of the Nation's health maintenance organizations or HMOs.

This figure includes 80 health plans enrolling two-thirds of the Medicare beneficiaries in TEFRA risk contracts. Our accreditation standards are continuously evolving to reflect changes in health plan and market structure as well as purchaser and consumer concerns.

In our accreditation process, we look at six areas of plan performance; the quality management system of the health plan, the credentialing system for providers, the member rates and responsibility systems including complaints and grievances, member survey information and any other information that is provided to members, the utilization management system, preventive health services systems, and medical records systems.

Less than one-third of the health plans that we have reviewed against our standards have received full accreditation, and 12 percent have been denied accreditation.

Does that buzzer mean something?

Chairman THOMAS. It does, but ignore it, as we do.

Ms. O'KANE. The primary reason that so many health plans have undergone this rigorous process is the purchaser's interest in ensuring that their employees are only enrolled in quality organizations.

Large employers such as Xerox, GTE, Ameritech, IBM, Allied Signal, the States of New York and Ohio and many others have all required that the health plans with whom they contract seek NCQA accreditation. Last June, we began releasing the NCQA accreditation status list free of charge to any individual who phones or writes our offices.

In addition to this listing of all plans and their accreditation decisions, NCQA will begin providing summary reports of our accreditation reviews later this year so that purchasers and consumers will have even more information with which to evaluate health plans. In addition to accreditation, NCQA has developed a system for measuring health plan performance.

In 1993 we released the Health Plan Employer Data and Information Set 2.0, a set of 60 standardized measures of health plan performance in five areas. A recent survey by the Physician Payment Review Commission found that 84 percent of health plans were reviewing HEDIS to generate performance indicators or assess their ability to generate these measures in the future.

HEDIS covers five areas of health plans performance, quality, access and patient satisfaction, membership and utilization, finance, and health plan management and activities. This month NCQA released HEDIS 2.5, a comprehensive update of the specifications in 2.0 as part of our commitment to a continuously improving system of health plan performance measurement. Work on HEDIS 3.0 will begin later this year and we look forward to moving health plan performance to new levels.

While HEDIS was initially designed for commercial purchasers, it is important that health plans be held equally accountable for the quality of care that they deliver to all members regardless of who is paying for their services. With funding from the Packard

Foundation, NCQA is directing a project to create a set of comprehensive performance measures which address the unique issues of the Medicaid population. In the future we look forward to exploring how HEDIS might be enhanced for the Medicare population as well.

To better understand the challenges associated with producing, auditing and displaying health plan report card data, we conducted a year-long report card pilot project which just recently concluded. The project had 21 participating health plans covering over 9.6 million enrollees and used a subset of the HEDIS measures. This pilot project confirmed that external auditing is critical to any report card effort, particularly in light of the public's skepticism with provision of performance information.

We learned the degree to which health plan information systems vary, and we encourage investment to enhance clinical information systems within the overall managed-care industry to further quality measurement and data comparability goals. As a result of the project, we also look forward to developing new measures as part of the development for HEDIS 3.0.

Additional research is needed on the potential for developing and integrating risk adjustment into future report card efforts. While consumers are not generally accustomed to getting information on health plan quality, we are doing research which shows that they are excited by the potential of health plan report cards. With support from the Commonwealth Fund, NCQA has completed two parts of a three-part consumer information project to assess the consumer perspective on quality.

This includes an examination of what consumers want to know, what kinds of technical quality information they find compelling, how much information is enough, and how much is overwhelming and how the information should be presented. As a result of our research, we have found that consumers are not generally accustomed to getting information on quality of health plans. However, once introduced to the idea of report cards for health plans, consumers are very interested in the potential.

As you might imagine, consumers would prefer to see report cards that show clear differences among health plans. However, because the differences are sometimes subtle, we are researching consumer preferences on information format and presentation. When asked about issues specific to the health plan itself, most consumers identify physician choice as their first assessment of a health plan's quality.

We found that quality measures such as immunization rates and mammography do extend consumers' thinking about the role of their health plan. These quality measures give consumers a better understanding about what their health plan is responsible for providing.

While excited by these findings, we believe it is a mistake to define consumers' future information needs in terms of today. All health plans, regardless of their financing and delivery structure, should be held accountable for the quality of services and medical delivery. All health plans must be required to provide data on quality performance, or those more structured, that have invested in in-

formation and clinical management systems, could be put at a disadvantage in the marketplace.

Just as many States such as Pennsylvania, Florida and Kansas have coordinated their regulation of health plans with our accreditation program, so, too, could the Federal Government. NCQA will have accredited over half the Nation's HMOs by the end of this year, a figure which includes health plans responsible for 66 percent of the seniors that are currently in Medicare risk contracts. Because the plans assume the cost of the review, the Federal Government could receive a benefit at no additional cost.

While NCQA accreditation should not be a condition of participation in the Medicare Program, health plans which have achieved accreditation should not be subject to redundant HCFA certification processes. We recognize that reducing the rate of growth in the Medicare Program is a critical component of deficit reduction efforts and we believe there is real potential to reduce costs while improving quality through the use of managed care.

However, we urge the Subcommittee to build on the work of this hearing and ensure that efforts to reduce cost do not compromise quality in the process. Thank you for the opportunity to testify.

[The prepared statement follows:]

TESTIMONY OF MARGARET E. O'KANE
NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA)

Good morning Mr. Chairman and members of the Subcommittee. I am Margaret E. O'Kane, President of the National Committee for Quality Assurance. We are pleased to have the opportunity to testify today before the Subcommittee on the important topic of private sector developments in quality measurement and improvement. As the Congress examines the private sector's efforts to reduce the rate of growth in health care costs, I commend the Chairman for convening this hearing to explore the equally important subject of private sector quality improvement initiatives.

The National Committee for Quality Assurance (NCQA) is an independent, non-profit organization which oversees two complementary approaches to health plan evaluation: accreditation and performance measurement. NCQA accreditation examines a health plan's infrastructure, while clinical and service performance is measured through NCQA's Health Plan Employer Data and Information Set (HEDIS 2.0 and 2.5). NCQA promotes improvements through the development and application of detailed standards for continuous quality improvement and measures of performance for health plans.

NCQA is governed by a Board of Directors which includes large purchasers (Federal Express, Xerox, CalPERS, and General Electric), health plan representatives, a consumer representative, a state legislator, a United Auto Workers representative, an American Medical Association representative, the NCQA President, and independent quality experts.

My testimony today will focus on four areas:

1. NCQA Accreditation
2. Measuring Health Plan Performance Through NCQA's HEDIS
3. Quality Information and Consumers
4. Future of Health Plan Quality Measurement and Improvement

NCQA Accreditation

By the end of this year, NCQA will have accredited over half of the nation's health maintenance organizations (HMOs). This figure includes eighty HMOs and CMPs enrolling two thirds of the Medicare beneficiaries in TEFRA risk contracts. Our Accreditation Standards are continuously evolving to reflect changes in health plan and market structure, as well as purchaser and consumer concerns. While a copy of the NCQA Standards was submitted to the Subcommittee, I will briefly summarize each of the six sections:

- *Quality Improvement:* What improvements in care and service can the Plan demonstrate? Does the plan full examine the quality of care given to its members? How well does the plan coordinate all parts of its delivery system? What steps does it take to make sure members have access to care in a reasonable amount of time?

- *Provider Credentials:* Does the Plan meet specific NCQA requirements for investigating the training and experience of all physicians in its network? Does the Plan keep track of all physicians' performance and use that information for their periodic evaluations? Does the Plan look for any history of malpractice or fraud? Has the Plan performed a quality assessment for health delivery organizations such as hospitals, home health agencies, nursing homes, and free-standing surgical centers?

- *Members' Rights and Responsibilities:* How clearly does the Plan inform members about how to access services, how to choose a physician or change physicians, and how to make a complaint? How responsive is the Plan to members' satisfaction ratings and complaints? Does the appeals process for grievances include a second review with different individuals?

- *Utilization Management:* Does the Plan use a reasonable and consistent process when deciding what health care services are appropriate for individuals needs? Are appropriateness criteria clearly documented and available to participating physicians? When the Plan denies payment for services, does it respond to member and physician appeals? Are physician consultants from the appropriate specialty areas of medicine and surgery utilized as needed?

- *Preventive Health Services:* Does the Plan encourage members to have preventive tests and immunizations? Does the Plan ensure that its physicians are encouraging and delivering preventive services?

- *Medical Records:* How consistently do medical records kept by the plan's physicians meet NCQA standards for quality care? For instance, do the records show that physicians follow up on patients' abnormal test findings?

A typical survey team for a 50,000 member HMO consists of three physicians and an administrative reviewer who spend three to four days at the health plan. For larger health plans, the number of physicians and length of time spent on-site is increased accordingly. Following an internal review by NCQA staff, the reports generated by the survey teams are forwarded to the all-physician Review Oversight Committee for a final decision.

The driving force behind NCQA Accreditation, and the primary reason that over half the nation's HMOs will be accredited by years' end, is the purchasers' interest in ensuring that their employees are only enrolled in a quality organization. Large employers such as Xerox, GTE, Bell Helicopter, Ameritech, IBM, Allied Signal, the States of New York and Ohio, Bristol Myers, General Electric, and many others have all required that the health plans with whom they contract seek NCQA accreditation. While large employers have accreditation mandates, accreditation results are in the public domain and thus shared amongst all employers and consumers.

In addition to purchasers, many states have coordinated their regulation of health plans with NCQA accreditation. Vermont has recently joined Pennsylvania, Florida, Kansas, and Oklahoma in either requiring that health plans undergo an external review by an independent organization or allowing accreditation to substitute for state reviews. Washington State has proposed similar regulations, and discussions are underway in many other states. We believe the federal government could similarly benefit by reducing duplicative oversight activities for those organizations that have achieved accreditation. While NCQA Accreditation should not be a condition of contracting for HMOs and CMPs, those plans which have achieved accreditation should not be subjected to redundant HCFA certification processes.

Last June, we began releasing a list of the accreditation status of every health plan reviewed by NCQA, as well as those scheduled for review. Updated monthly, the NCQA Accreditation Status List is available free of charge to any individual who phones or writes our offices. Since first releasing the list, NCQA has mailed out more than 2,500 copies to individuals and organizations across the country. Beginning this July, NCQA will provide summary reports of accreditation reviews, so that purchasers and consumers will have even more information with which to evaluate health plans. I will briefly outline the most recent accreditation statistics:

Full Accreditation (32 percent) is granted for a period of three years to those plans that have excellent programs for continuous quality improvement and meet NCQA's rigorous standards.

One Year Accreditation (40 percent) is granted to plans that have well-established quality improvement programs and meet most NCQA standards. NCQA provides the plans with a specific list of recommendations, and reviews the plans again after a year to determine if they have progressed enough to move up to Full Accreditation.

Provisional Accreditation (15 percent) is granted for one year to plans that have adequate quality improvement programs and meet some NCQA standards. These plans need to demonstrate progress before they can qualify for higher levels of accreditation.

Denial of Accreditation (12 percent) is given to those plans that do not qualify for any of the categories above.

Since NCQA began reviewing health plans, we have witnessed real improvements in the capability and sophistication of health plan quality improvement efforts. While these improvements are encouraging, our accreditation statistics are more reflective of a deliberate decision to set the NCQA Standards very high. The NCQA standards reflect the thinking of the most demanding corporate purchasers in the market, and should not be confused with entry-level requirements.

Measuring Health Plan Performance Through HEDIS

In November 1993 NCQA released the Health Plan Employer Data and Information Set HEDIS 2.0, a set of sixty standardized measures of health plan performance in five areas. While a copy of HEDIS 2.0 has been submitted to the Subcommittee, I will briefly summarize the five areas:

Quality - Measuring health plans' performance in the delivery of selected services in the areas of Preventive Medicine, Prenatal Care, Acute and Chronic Disease, and Mental Health.

Access and Patient Satisfaction - Measuring health plans' performance in providing members access to health care and in satisfying members.

Membership and Utilization - Measuring health plans' performance regarding membership stability and demographics as well as resource allocation within the plan.

Finance - Measuring health plans' performance in achieving financial stability by examining liquidity, efficiency, premium trend information, and compliance with statutory requirements.

Health Plan Management and Activities - Assessing health plans' management that can affect members' health, satisfaction, and use of services.

This month, NCQA released HEDIS 2.5, a comprehensive update of the specifications in HEDIS 2.0, as part of our commitment to a continuously improving standard for health plan performance measurement. Work on HEDIS 3.0 will begin later this year and we look forward to moving health plan performance measurement to new levels.

A recent survey by the Physician Payment Review Commission (Gold et al. 1995) found that 84 percent of health plans, including both HMOs and PPOs, were reviewing HEDIS to generate performance indicators or assess their ability to generate indicators in the future. Large employers and business groups from around the country have embraced HEDIS as the core set of measures to evaluate health plan performance.

While HEDIS was initially designed for commercial purchasers, it is important that health plans be held equally accountable for the quality of care they deliver to all members, regardless of the payor relationship. With funding from the David and Lucile Packard Foundation, NCQA is directing a project to create a set of comprehensive performance measures addressing the unique characteristics of the Medicaid population. On this project NCQA is working with HCFA, the State Medicaid Directors Group, and the states of Wisconsin, Minnesota, California, Oregon, New York, and Massachusetts. By building on the work of the private sector, the Medicaid HEDIS Project is a model for coordinating

public and private payor data demands. In the future, we look forward to exploring how HEDIS might be adapted for the Medicare population as well.

The twin goals of measuring health plan performance are to improve quality and assist individuals and organizations with their purchasing decisions. Given the complexities of risk adjustment and the wide variation in health plan data systems, however, HEDIS data is best used now for comparing one health plan's performance over time or against national goals where they exist. In the future, we fully expect that HEDIS data will be used as part of a "report card" for purchasers and consumers to compare the performance of one health plan against another and against national benchmarks.

To more fully explore the challenges associated with producing, auditing, and displaying health plan "report card" data, NCQA announced its Report Card Pilot Project in January 1994 with 21 participating health plans covering over 9.6 million enrollee. The Project concluded last month with a symposium here in Washington D.C. Thirty-eight of the HEDIS 2.0 measures were selected and refined for inclusion in the final report. While a copy of the Executive Summary and the Technical Report was submitted to the Subcommittee, I will briefly summarize the results in my testimony today:

External Auditing is Critical - The audit process is essential to the credible implementation of any report card effort. To ensure the validity and accuracy of the data in the Report Card Pilot Project, NCQA designed a two part audit. The first component was a self-reported baseline assessment of systems capabilities, which includes detailed diagrams of claims processing systems and supporting documentation from the participating plans. To validate the self-reported findings, we performed an on-site audit that placed special emphasis on those areas prone to data "fallout" and errors, as well as data acquisition and health plan characteristics that might influence data quality or completeness. For further verification of accuracy, the audit teams compared a subset of the actual administrative data against medical records or other source documents.

Health Plan Information Systems - Greater standardization of common data sets would enhance comparability and data integrity. Enhanced standardization would also reduce the audit burden, which is greatly increased by differences in the content, completeness, coding, and reliability of various data sets. NCQA encourages investment to enhance clinical information systems within the overall managed care industry to further quality measurement and data comparability goals.

Enhancement of Performance Measures - While the performance measures used in the Pilot Project were drawn from HEDIS 2.0, additional measures must be developed to ensure that report cards reflect the range of key clinical areas and meet the information needs of consumers. NCQA looks forward to developing these measures as part of the development process for HEDIS 3.0. Additional research is also needed on the potential for developing and integrating risk adjustment into future report card efforts.

Consumer Needs and Quality Information

Without information on quality and cost, consumers cannot judge value. While consumers are not generally accustomed to getting information on health plan quality, our research has shown they are excited by the potential of health plan report cards. Quality measures give consumers an appreciation of what a health plan is responsible for providing. When consumers learn that their health plan should be coordinating their care and providing a network of credentialed physicians, they become interested in the corresponding performance measures. Consumers also want more information on operational issues. Meeting these diverse needs for information with clear and compelling data is one of the greatest challenges in this field.

While helpful to consumers, public release of the Accreditation Status List and our future accreditation summary reports are only part of NCQA's outreach and research into consumer information needs. With support from the Commonwealth Fund, NCQA has completed two parts of a three-part Consumer Information Project to assess the consumer perspective on quality. This includes an examination of:

- What consumers want to know
- What kind of technical quality information they find compelling
- How much information is enough and how much is overwhelming
- How should the information should be presented

The first phase of the project consisted of in-depth consumer interviews and one focus group. The second phase included six consumer focus groups held in Seattle, Denver, and Philadelphia. The Agency for Health Care Policy and Research provided support for four of these six consumer focus groups. The third and final stage is planned as a demonstration and study of how consumers use report card information to make actual purchasing decisions in two metropolitan markets. We have also completed an HMO report card pilot project for the State of Maryland Health Care Access and Cost Commission which included consumer, provider, and employer focus groups.

As a result of this research we have found that consumers are not generally accustomed to getting information on health plan quality. However, once introduced to the idea of health plan report cards consumers become excited by the potential. As you might imagine, consumers would prefer to see report cards that show clear differences among health plans. However, because the differences among plans are often subtle, NCQA is researching consumer preferences on information format and presentation. While some consumers want overall health plan ratings and others more detailed reports, all consumers want to choose value.

When asked about issues specific to the health plan itself, most consumers identify physician choice ("Is my physician or a physician I choose on the list?") as their first assessment of a health plan's quality. Consumers also want more information on operational issues such as out-of-pocket costs and how the plan works. Consumers also identified accessibility and convenience, along with prevention and educational outreach activities as important concerns.

We found that quality measures (such as immunization and mammography rates) expand consumers' thinking about their health plan. Quality measures give consumers a better understanding of what their health plan is responsible for providing. When consumers learn that their health plan is responsible for coordinating their care and providing a network of credentialed physicians, they become interested in corresponding performance measures. National averages or industry standards are also helpful for consumers to make comparisons. While excited by these findings, we believe it a mistake to define or limit future consumers' information needs with today's expectations.

We have also become aware of a strong undercurrent of public skepticism relating to the provision of information. For example, there was a unanimous desire to know who was behind any rating efforts. Overall, it was felt that few organizations would publish the "bad" ratings. We are now entering an era when the release of spurious quality data could endanger the future of this field by validating the public's skepticism. As we go forward, we must continually emphasize the importance of a third party audit to ensure veracity. The challenge for policymakers is to both address and overcome the public's skepticism.

Future of Health Plan Quality Measurement and Improvement

I want to preface this section by noting that my remarks will pertain almost exclusively to quality measurement and improvement in HMOs. Preferred provider organizations (PPOs) and Physician hospital organizations (PHOs) are currently unregulated by the majority of states, and any discussion of health plan quality must begin with an acknowledgement of these gaps in the regulatory spectrum.

NCQA believes that all health plans, regardless of their financing and delivery structure, should be held accountable for the quality of services and medical delivery. Delivery systems such as managed indemnity and PPOs should at least be required to: credential their providers; monitor services and delivery complaints and grievances; implement standards for utilization management; and provide data about member satisfaction and clinical performance. All health plans must be required to provide data on quality performance, or those more structured plans that have invested in information and clinical management systems could be put at a disadvantage in the marketplace.

Competition in the health care marketplace is unique in the sense that innovations in quality improvement should often be shared in the interest of improving public health. Goals for HEDIS have been tied to important public health goals, such as those in Healthy People 2000. Through conferences and professional publications, NCQA is facilitating a national dialogue on quality improvement in managed care organizations. Having reviewed so many health plans from around the country we are in a unique position to identify best practices and facilitate a supportive learning atmosphere.

Just as many states have begun exploring the relationship between regulation and private sector accreditation, so to should the federal government. As mentioned earlier, NCQA will have accredited over half the nation's HMOs by the end of this year; a figure which includes health plans responsible for 66 percent of the seniors enrolled in TEFRA Medicare Risk Contracts. Because the health plans assume the cost of the review, the federal government receives a benefit at no additional cost. While NCQA Accreditation should not be a condition of participation in the Medicare program, health plans which have achieved accreditation should not be subjected to redundant HCFA certification processes.

NCQA recognizes that reducing the rate of growth in the Medicare program is a critical component of deficit reduction efforts. We believe there is real potential to reduce costs and improve quality through the use of managed care. However, we urge the Subcommittee to build on the work of this hearing and ensure that efforts to reduce costs do not compromise quality in the process.

Thank you again Mr. Chairman for holding this important hearing and providing the National Committee for Quality Assurance with the opportunity to testify.

Chairman THOMAS. Thank you. Dr. O'Leary.

STATEMENT OF DENNIS S. O'LEARY, M.D., PRESIDENT, JOINT COMMISSION ON ACCREDITATION OF HEALTH CARE ORGANIZATIONS

Dr. O'LEARY. I am Dennis O'Leary, president of the Joint Commission on Accreditation of Health Care Organizations. We are most appreciative of the opportunity to testify before the Subcommittee.

Long before the enactment of the Medicare Program, the Joint Commission was established by the American College of Surgeons and other leadership organizations in the health care field that were and are committed to providing quality health care in this country. We remain the longest established health care accrediting body in the world, evaluating nearly 11,000 health care organizations, including managed care networks.

Today, I want to make two points to the Subcommittee. The first is that new and effective tools are available to measure quality of care in the complex and still evolving array of health plans across the country. These are important and necessary resources for evaluating the impacts of continuing change in health care.

The second is that Medicare should consider expanding its existing quality of care partnerships with the private sector as it plans for the significant future use of managed care by its beneficiaries. To do so will help ensure that we maintain and improve upon the best available health care in the world.

Let me begin by describing the Joint Commission's quality measurement framework for managed care systems. The Joint Commission's process for measuring quality has changed significantly during the last decade. We now have made a major and successful transition to a performance-based measurement system that is flexible, patient-focused and keyed to improving health outcomes.

These are critical elements to the design of a quality oversight program for managed care systems because they permit meaningful assessment of health plans regardless of their size, configuration or scope of services.

Our standards for managed care networks are built around the key functions that a health plan must carry out well in order to achieve good patient outcomes. This is a crucial focus, because a managed care network is more than the sum of its parts. It must integrate services across multiple and differing sites of care and assure that the needs of its enrollees are met at all points along the continuum of care. How well a network performs its functions has a large bearing on enrollee outcomes, the costs of care and the health status of the population served.

Moreover, setting standards in this manner as performance objectives around key functions is essential in a rapidly changing environment where care must be taken to avoid prescriptive requirements that could impede market entry for new types of delivery systems.

Examples of key functions addressed in our standards include the following; coordination of enrollee services along the service continuum, second, the management of information to ensure its timely availability at each site of care, third, the management of

human resources to ensure the appropriate number, type, and mix of qualified personnel to carry out the plan's obligations, fourth, the intranetwork education of and communication with enrollees and plan providers and practitioners, and finally, continuous measurement evaluation, and improvement of performance.

This last function, continuous quality improvement, is the cornerstone of the Joint Commission's new Integrated Network Accreditation Program. We see our job as sowing the seeds for internal quality improvement programs that their plans inculcate and operate as a sound business practice.

The second Joint Commission initiative is the establishment of a comprehensive database of performance indicators that address a range of quality issues such as access to services, enrollee satisfaction, health outcomes and functional status. Indicators address the results of care, and although inherently retrospective, often provide valuable insights as to internal systems changes that would improve future care.

Today, after extensive development and testing, the Joint Commission has a modern set of clinical indicators called the IMSystem that covers such areas as medication usage, cardiovascular care and trauma care. The Joint Commission is now expanding its inventory of indicators to include those developed by others. Nevertheless, establishing a comprehensive database of properly tested indicators is a daunting challenge and one that could certainly benefit from further public/private sector collaboration to standardize the measures.

The Joint Commission has had a long and productive partnership with the Federal Government in overseeing quality in the Nation's health care delivery organizations. This partnership provides a useful framework for meeting the challenges of quality evaluation as the country moves toward new models of health care delivery.

When the Medicare Program was enacted in the sixties the government looked to the Joint Commission's state-of-the-art standards to help craft its quality standards for hospitals. The Government also relied upon the Joint Commission's surveyors and its evaluation process for certifying hospitals.

This partnership has led to a consistent level of expectations for quality across the country. As new types of providers have been brought under Medicare, this partnership has been expanded to include home health, ambulatory surgery and laboratories. However, no such partnership arrangement exists for Medicare managed care organizations.

This is not the time to build a large government bureaucracy to oversee an evolving market nor is it the time to turn less than an acute ear to consumers reticent to choose managed care without the promise of quality protections. We need to join together drawing upon the Federal Government's leadership in funding outcomes research, clinical practice guidelines and other tools used in quality evaluation and for enforcement where necessary.

The private sector should be drawn upon for its expertise in actually developing state-of-the-art standards and performance measures, and for implementing large-scale quality oversight programs. Thank you.

[The prepared statement follows:]

TESTIMONY OF DENNIS S. O'LEARY, M.D.
ACCREDITATION OF HEALTH CARE ORGANIZATIONS

I am Dr. Dennis O'Leary, President of the Joint Commission on Accreditation of Healthcare Organizations. We appreciate your invitation to appear before the Subcommittee on this extremely important topic.

The demise of last year's national health care reform initiatives has not slowed, and in fact may have stimulated, the expansion of new models of health care delivery. This evolution is being driven by both the need and the opportunity to create more efficient mechanisms for providing a broad array of services. The new entities being formed have increasingly complex and sophisticated relationships, reflecting state-of-the-art thinking about approaches to health care delivery, but also create anxieties among the public as to whether due attention is being paid to the quality of the services and care being delivered.

This presents a major challenge to those in the private and public sectors involved with developing and implementing quality oversight systems. We must have measurement programs that are relevant to widely varied service arrangements and configurations. We must address ourselves to consumer concerns about disincentives for quality in a changing environment and to consumer demands for useful information to help them make important decisions about their care. An we must incorporate the evolving focus by purchasers and policymakers on population-based health, disease prevention, health promotion, outcomes, and consumer satisfaction.

The Medicare program must also face the fact that quality measurement in the 1990s is different and more complex than ever before. Medicare should anticipate and plan for significant future use of managed care by its beneficiaries, make sure that it has a construct for quality oversight that will satisfy the public, and take advantage of rapidly emerging, cutting-edge private sector initiatives. New types of delivery systems pose unique quality issues for all of us, but fortunately the government and the public can benefit from seminal work done over the past ten years in the private sector, and from a public/private partnership framework that has served the public well for the last thirty years.

The Partnership

The Joint Commission has had a long and productive partnership with the federal government overseeing quality in the nation's health care delivery organizations. This is a partnership that we value and one that continues to provide a useful framework for meeting the challenges of quality oversight as the country moves toward new models of health care delivery. This partnership marries market incentives to achieve formal recognition as a provider of quality evaluation services with the enforcement powers of the government where necessary.

When the Medicare program was enacted in the mid 1960s, the government recognized the important contributions that the private sector could make to the protection of the elderly. The Medicare insurance program was centered around hospital-based care. The government looked to the Joint Commission's state-of-the-art hospital standards to help craft Medicare's Conditions of Participation -- its quality standards for hospitals. Faced with the enormous task of determining the compliance of thousands of hospitals with those conditions, the government recognized that it could extend its limited dollar and human resources by relying upon the Joint Commission's cadre of experienced surveyors and its evaluation and decisionmaking processes for the purpose of certifying hospitals. At the same time, The federal Conditions of Participation would offer a public route of entry for those hospitals unable to comply with accreditation standards.

We believe that this partnership has worked well for all parties and has led to the continuous upgrading of care in the United States. And it has resulted in a consistent level of expectations for quality across the country. In fact, accreditation standards are reflected in most state licensure laws, and in legal decisions by the courts. However, the most notable benefits from the partnership have been incentives to providers for achieving optimal standards of care and assurances to the public that poor performers will lose their Medicare certification. Further, I believe that the give and take over the years regarding federal versus private sector performance expectations has served to improve each partner's contributions, while serving as a major stimulus for hospitals and other types of provider organizations to provide the best available care in the world.

As new types of providers and suppliers have been brought into the Medicare reimbursement system, this partnership has been expanded to nonhospital-based service organizations, such as home health, ambulatory surgery, and laboratories; and also to other national accrediting bodies specializing in specific areas. However, no formalized partnership arrangement exists for Medicare managed care organizations.

Quality Measurement Has Changed

The Joint Commission's process for measuring quality has evolved significantly since the mid 1980's when we began our Agenda for Change. The Agenda for Change has involved the creation of a performance-based measurement system that is flexible, patient-focused, and concerned with improving health outcomes. The advances in the state-of-the-art of quality measurement and evaluation have critical implications for quality oversight of managed care systems, because they permit contemporary and meaningful assessment of health plans regardless of their size, configuration, or scope of services.

I would like to describe three major components of the Joint Commission's new approach to quality evaluation and demonstrate how they are relevant to managed care plans.

The Recasting of Accreditation Standards

First, standards for all our accreditation programs have been rewritten around the key functions that an organization must carry out effectively in order to achieve good patient outcomes. This may appear simplistic, but it is a crucial principle in designing a quality and evaluation approach for complex entities like health plans. A managed care network is more than the simple sum of its parts; it is defined by its responsibility for integrating services across multiple and differing sites of care, and for assuring that the needs of its enrollees are met along the full continuum of care. How well a network performs its functions has a large bearing on enrollee outcomes, the cost of providing effective and appropriate services, and the eventual health status of the population served.

Moreover, setting standards in this manner -- as performance objectives around key functions -- is essential in a rapidly changing environment. Establishing prescriptive requirements would simply impede market entry as new delivery systems and products continue to evolve.

As has been our tradition, we drew upon the expertise of a broad array of stakeholders to develop the managed care network standards published by the Joint Commission last year. These standards constitute a comprehensive framework of performance objectives for the complex delivery systems of today and

tomorrow, regardless of their specific configurations. Some of the most important functions addressed in the standards are the coordination of enrollee services along the service continuum; the management of information to ensure its timely availability at each site of care; the management of human resources to ensure the appropriate number, type and mix of qualified personnel to carry out the plan's obligations; and intra-network education of and communication with both enrollees and plan providers. These dynamic functions require that the network's brain continuously address issues of coordination, integration, and communication while also setting network goals and assuring the appropriate allocation of resources, and continuously measuring, assessing and improving the network's performance.

That's why the Joint Commission's standards also emphasize the role of plan leadership in overseeing all of the network's key functions. Let me use "leadership" as an example of our new way of expressing performance expectations and how these apply to networks. Our old standards relied on each department in a hospital to provide leadership to its service. Consonant with our performance-based standards, that leadership responsibility has shifted to the hospital's management, clinical leadership and governance structures which are also required to determine the needs of the organization's community and plan for the provisions of appropriate hospital services. The comparable requirements for networks require the plan's central, identified leadership to be cognizant of the expectations of its enrollees; seek and listen to enrollee feedback, and actively work to address the identified needs.

The cornerstone standards in our new Network Accreditation program address the network's responsibility for continuously improving its performance. We emphasize these standards because quality is not achieved simply by the performance of periodic surveys. We see the Joint Commission's role as sowing the seeds for internal quality improvement programs that continuously measure, evaluate and improve performance. Instilling internal incentives for systems improvements at the local level is our primary objective, and it should, we believe, be the objective of all external review activities.

In recent years, we have seen great strides in the development of measurement tools to support quality improvement activities, such as reference databases, clinical practice guidelines, functional status and quality of life measures, and others. Moreover, many health care networks have begun to adopt some of the many approaches to CQI and TQM that have been popularized by American industry. Those of us who are onsite in these networks are in a unique position to provide technical assistance to providers and plans in establishing quality improvement programs. We can also determine whether their problem detection and solving processes are actually working, as we conduct interviews with patients and staff. This is a unique and invaluable aspect of the accreditation process.

The Development of Quality Indicators

A second initiative has been the development of a system of quality indicators that can be applied to accredited health care organizations on an ongoing basis and can be used both as early warning signs of potential problems and as continuous markers of quality improvement opportunities. Indicators address the results of care provided and, although inherently retrospective, often provide insights as to potential systems changes that would improve future care. Used in conjunction with accreditation standards, indicators make possible a comprehensive evaluation system that is both precise in the information that it gathers and predictive of future organization performance.

Today, after extensive development and testing activities, the Joint Commission has a modern performance measurement system and database called the IMSystem. The IMSystem encompasses a steadily expanding base of important clinical indicators that cover such areas as medication errors, infection control, trauma care and oncology services.

Let me give you an example of how a network indicator might differ from one used in a single site provider, like a hospital. If we were examining total hip replacement in a hospital, we might confine ourselves to measuring the appropriate use of the procedure, its technical performance, and the planning for the patient's transition to home. When looking at the same service in a network, we would go beyond those measures to address issues such as access to hip replacement surgery, coordination of follow-up care, and the patient's ability to function, including his or her ability to return to work. These added dimensions reflect enrollee expectations regarding the network's performance of its important functions.

We are now expanding our inventory of measures to include those developed by others. This will permit rapid expansion of the database to provide accredited organizations with to meet their varied needs and those of their enrollees.

Establishing an inventory of properly tested measures for use in managed care organizations is a daunting challenge and one that could certainly benefit from further private/public sector collaboration. The Joint Commission recently issued invitations to more than 250 organizations to solicit their involvement in a partnership of sharing performance indicators. We have had a very good response thus far. There is still a need, however, to standardize the measures in the inventory. If we are to have useful information, the performance data gathered from health plans must be comparable. Measures must also be valid, relevant to patient outcomes, and reliable. Otherwise we will waste a major investment in performance measurement and data collection activities.

Public Disclosure

A third initiative that came to fruition last year was the implementation of our new policy on disclosure of performance information about accredited organizations. We developed and began to make available to the public last December our first performance reports on accredited organizations. This, we believe, is part of our public trust. As the major gatherer and keeper of important performance information on 11,000 health care organizations, we have an obligation to share this information with today's increasingly knowledgeable and interested public.

Managed care plans are under increasing pressure to provide information to the consumer about their services, administrative policies, and key dimensions of quality. The challenge will be to produce reports that are truly helpful to those using the information to choose among plans. More clearly needs to be done to determine what consumers most want to know about plans, and how this information is best presented.

We believe that our new initiatives involving standards, indicators and public performance reports provide an important framework applicable to all types of service delivery and configurations. None of these parts can be taken in isolation. There are no data sytems, whether designed to capture routine outcomes or encounter data, that can substitute for onsite survey of a managed care network. There is no substitute for talking directly to patients and to practitioners; to visiting high risk and low risk sites of care; to observing first hand the underlying processes in action and what they are likely to produce. All the elements described in our testimony are essential to building and maintaining public confidence in the future health care delivery system in the United States.

Chairman THOMAS. Thank you very much. Dr. Bee.

STATEMENT OF DAVID M. BEE, M.D., VICE PRESIDENT, AMERICAN MEDICAL PEER REVIEW ASSOCIATION

Dr. BEE. Good afternoon, Mr. Chairman and Members of the Committee. My name is David Bee. I am a board-certified internist and have practiced in Glendale, CA, for about 20 years, 10 as a contracted IPA, independent practice associations, provider to 10 different HMO plans. I have also been a board member of the California PRO, CMRI.

I was one of the founders and also served a couple of years as the President of the California PRO. For the last year and a half I have been a full-time district medical director for FHP. I think I have seen a broad spectrum of health care as it has evolved over the last 20 years.

I am very pleased to represent AMPRA, the American Medical Peer Review Association. AMPRA is a national organization, membership association of quality improvement organizations, which includes all of the peer review organizations around the 50 States. I currently serve as AMPRA's vice president. AMPRA supports public and private efforts to protect and improve the quality of health care.

We want to do that through services involving active sponsorship of both internal and external quality management systems and we thank the Subcommittee for focusing attention today on this very important issue.

America's peer review organizations are private sector independent entities representing thousands of community-based physicians, nurses and other health care professionals, most of whom have had a very long commitment to continuous quality improvement of the health care system. PRO's collaborate with all community providers of health care, including employer groups, Medicare and Medicaid Programs, the AHCPR, State health departments, and consumers. We are seeking to impact the quality of health care and we are using the quality improvement tools of industry.

Mr. Chairman, 9 years ago this Subcommittee, with a laudable mission, drafted section 9313 of the Budget Act of 1986. This section commissioned the Institute of Medicine to design a strategy for quality review and assurance in Medicare. The Institute's 1990 report to Congress became the blueprint for reengineering Medicare's PRO program, which has evolved into the HCQIP described for you today. We strongly direct your attention to the fact that the HCQIP enjoys widespread support from numerous provider and Medicare beneficiary groups, as you will later hear.

Our written testimony before you describes several of the over 400 current projects already improving access, process, outcome and cost across the country. These projects have only been initiated for about the past 2 years and should be considered preliminary. However, the findings are quite encouraging.

I heard Dr. Vladeck say that he was not willing to put any cost saving numbers on the projects that are underway. A couple of our member PROs have been willing to project some cost savings.

In Arizona, using tools to stimulate the community to reduce inappropriate surgery for cancer of the prostate, the numbers gen-

erated their project into about $1.08 billion in savings if they are equally successful across the country. I must point out that the 1.7 number in your testimony was a typographical error.

Over 20 States, including my own State, are participating in stroke prevention projects and the Michigan PRO, using just 19 of its State hospitals projected a saving of over $1 million in prevented strokes if the guidelines were appropriately followed.

You have heard the story of New York in preventing unnecessary heart catheterizations which are projected to save about $7 million. Through AMPRA's facilitation, about 16 other PROs around the country are using these same projects to try to improve the care in their community in the same way.

AMPRA and its members are committed to using community-based, locally controlled, effective interventions in health care. We believe that community physicians using nationally developed guidelines in cooperation with their local medical societies, with local physician groups and especially societies, can develop the kinds of projects that will actually move to push Dr. Jenck's beautiful curves in the direction that we wish them to go. We believe that is the mission of the PRO, the mission of AMPRA, and we believe that using these tools together we can forge a high quality future for American consumers.

In conclusion, there have been tremendous advances in building the science of quality measurement. There is scant evidence, however, that we have been able to translate practice guidelines, outcomes research and performance measures into sustained changes in practice behavior. The PROs have demonstrated a unique competency in facilitating and integrating quality management concepts and tools at the local physician hospital health plan level through the health care quality improvement project.

Mr. Chairman, we appreciate the opportunity to testify and look forward to working with the Committee in designing strategies for improving the quality of health care for all Americans. Thank you.

[The prepared statement follows:]

TESTIMONY OF DAVID M. BEE, M.D.
AMERICAN MEDICAL PEER REVIEW ASSOCIATION

1. The American Medical Peer Review Association (AMPRA) representing federally designated Peer Review Organizations (PROs), support public and private efforts to protect and improve the quality of health care services, through active sponsorship of both internal and external quality management systems and programs.
2. PROs share a mission to serve as a primary agent in focusing local community energy to achieve significant and continuing improvement in the quality and effectiveness of health care. PROs engage health care practitioners, health plans, purchasers and consumers in collaborative efforts by: monitoring health care patterns to identify opportunities for improvement and tracking progress toward achievement of the highest quality of care; interpreting and sharing information about care processes, health outcomes, and current science; and actively encouraging all parties to make positive changes in behavior that would improve the status of individuals and populations.
3. The Ways and Means Committee is to be complimented for its role in setting a new course for Medicare quality assurance. Nine years ago, the Subcommittee drafted Section 9313 of the Omnibus Budget Reconciliation Act of 1986 commissioning the Institute of Medicine (IOM) "to design a strategy for quality review and assurance in Medicare." The IOM's subsequent report became the blueprint for Medicare's Health Care Quality Improvement Program.
4. Medicare's Health Care Quality Improvement Program is an exciting and dynamic new partnership between beneficiaries, providers, PROs, and the Health Care Financing Administration to improve the quality of care for Medicare beneficiaries. In the over 400 local improvement projects that PROs have implemented to date, there is clear evidence that patient outcomes can be improved, dollars can be saved, and beneficiaries can be educated and empowered to make informed health care choices. As the program matures and successful efforts are replicated across the country, there is even greater potential for accelerating the pace of improvement and cost savings. In one project area alone, an effort to reduce the incidence of radical prostatectomies, if the results in four states were mirrored across the country, the Medicare program would save over $1.7 billion.
5. The growth of Medicare managed care is an inevitable result of the managed care revolution sweeping the private sector. There are both risks and benefits to patient care associated with prepaid delivery systems that suggest the need to strike an appropriate balance between external monitoring and reliance on the unique internal quality assurance and improvement capabilities of integrated health plans. In this regard, AMPRA supports the resolve of the Health Care Financing Administration to redesign PRO oversight of Medicare managed care to fit the model of the Health Care Quality Improvement Program and recommends the inclusion of Medicare risk contract populations in the quality improvement projects already in progress. AMPRA supports the Medicare health maintenance organization (HMO) performance measurement project, led by the Delmarva PRO and Harvard University, and urges its immediate pilot testing prior to national implementation. Finally, AMPRA supports the development of a minimum patient encounter data set for Medicare risk contract plans to be used in support of both internal and external quality management efforts.

Written Statement
of the
American Medical Peer Review Association

Mr. Chairman and members of the House Committee on Ways and Means Subcommittee on Health, my name is David M. Bee, M.D., F.A.C.P. I am a board certified practicing internist with 20 years of bedside internal medicine and critical care practice. Last year I became a full-time medical administrator for FHP, a multi-state managed care company based in California. I am past president and current board member of California Medical Review, Inc., the Medicare peer review organization (PRO) in California. I have been associated with quality assurance activities since 1974.

I am here today representing the American Medical Peer Review Association (AMPRA), where I currently serve as vice president.

AMPRA is a national membership association of independent quality evaluation and improvement organizations, which includes the PROs. As an association dedicated to quality health care through independent and community-based quality evaluation and improvement programs, we appreciate the invitation to testify and thank you for bringing needed attention and focus to the issue of quality health care.

My remarks today will focus on the quality assurance and improvement services provided by the AMPRA membership for the Medicare program as part of its Health Care Quality Improvement Program (HCQIP). This work includes quality evaluation of both Medicare fee-for-service and Medicare risk contract plans.

The Quality Challenge

Regardless of one's political persuasion, protecting and improving the quality of health care services while working to ensure access to those services is a goal we all share. We must work together to design internal and external strategies to continuously improve health status and the delivery of health care services in our communities. At a time when health care delivery is being rapidly transformed by managed care and when budget pressures are expected to reduce expenditures for Medicare and Medicaid, Americans deserve a comprehensive system of quality accountability.

For over two decades, the AMPRA membership has been committed to serving as a catalyst in focusing community energy to achieve significant and continuing improvement in the quality and effectiveness of health care. As a national network of private sector, independent organizations, we have been called on by Medicare, Medicaid, and private purchasers to:

- monitor health care patterns to identify opportunities for improvement and to track progress toward achievement of the highest quality of care;
- interpret and share information about care processes, health outcomes and current science;
- actively encourage all parties to make positive changes in behavior that would improve the health status of individuals and populations.

Let me underscore that our work in local communities is not confined to the measurement of quality. While we begin with the application of quality indicators/performance measures to pinpoint opportunities for improvement, our real success is determined by out ability to catalyze sustained improvement through changes in practice behavior, health care processes and individual decision-making.

Our experience teaches us that any comprehensive quality initiative must incorporate three important functions: continuous quality improvement; consumer education; and quality protection.

Continuous quality improvement ensures that all practitioners involved in the delivery of care strive to reach the highest quality of care achievable based on current scientific and professional knowledge. Continuous quality improvement enhances health outcomes for individuals while reducing the costs of care.

Consumer education empowers the individual to make appropriate choices (lifestyle, medical treatment, provider, health plan, etc.) based on reliable and understandable information.

Quality protection ensures that individuals and populations escape harm from providers not meeting minimally accepted standards of care.

We urge the subcommittee to keep these key functions in mind when analyzing public and private sector quality initiatives.

THE HEALTH CARE QUALITY IMPROVEMENT PROGRAM -- A Model of Government Re-engineering

I would now like to turn my attention to HCQIP. Mr. Chairman, nine years ago the ways and means subcommittee on health authored Section 9313 of the Omnibus Budget Reconciliation Act of 1986 which commissioned the Institute of Medicine (IOM) "...to design a strategy for quality review and assurance in Medicare." In 1990, after review and study by a national panel of experts, the IOM issued its report.

This innovative study, *Medicare: A Strategy for Quality Assurance* -- embraced by Congress, the Bush and Clinton administrations, and all participants in Medicare's quality assurance activities -- became the blueprint for Medicare's HCQIP. As the program name implies, PROs form partnerships among government, providers, and beneficiaries for the purpose of improving the quality of care delivered to Medicare beneficiaries.

As you will hear today, HCQIP has become a model for government re-engineering and

privatization. The Health Care Financing Administration (HCFA), to its credit, has relaxed the reins of central control and regulatory authority and empowered local communities to seek their own opportunities for quality improvement. In its short history, HCQIP has demonstrated the potential to improve health outcomes for beneficiaries while reducing costs and expenditures for Medicare providers and the Medicare program.

The Evolution of Health Care Quality

Mr. Chairman, in describing HCQIP, it is important to be reminded that quality improvement has become one of the core tenants of health policy over the past decade, contributing to a healthier, more productive population which in turn results in significant health care savings. This shift to quality improvement reveals a fundamental change in the way health care is delivered, practiced, and purchased.

In 1993 Medicare followed this shift, transforming its oversight program from one of peer review -- singling out individual poor performers identified after the fact -- to one of quality improvement, promoting good practices and continually identifying opportunities for improvement within health care facilities.

As PROs, we now serve as active participants in health care quality improvement, adopting a seamless approach which unites us with physicians, fee-for-service and managed care providers, consumers, accreditors, federal and state agencies and local community representatives. Specific emphasis is placed on actively involving these groups in developing improvement agendas, programs and projects. With the PRO acting as the change agent, this approach encourages cooperation among all participants in the community's health care delivery system and promotes removal of competitive barriers.

As catalysts for community-wide quality improvement, we bring improvement methods and tools to providers and communicate with beneficiaries and providers to promote informed health choices. Information is now available to Medicare beneficiaries that will promote individual participation in health care decision-making. More specifically, efforts are underway to educate individual beneficiaries about preventive health care, provide information about treatment options, and to promote increased health awareness in the senior population.

As with other purchasers of health care services in the private sector and the insurance industry, Medicare has the right to sever contracts with providers found to provide poor care. This is accomplished through the quality protection authority, conferred by statute to the Medicare program's agents, the PROs.

Lastly Mr. Chairman, PROs have become central to improving not only the health of Medicare beneficiaries, but of other recipients of health care. As the quality improvement changes for Medicare beneficiaries become institutionalized, all populations -- not just Medicare beneficiaries -- will benefit from and utilize these improved health processes. Indeed, we invite the private sector to join our Medicare-sponsored improvement activities when topics are relevant to the under 65 population.

Local Quality Improvement in Health Care Facilities

In identifying opportunities for improvement, PROs profile patterns of care from representative samples of practices and services. These samples are compared to quality indicators, based on published practice guidelines, research, or widely accepted practice parameters. The data are analyzed and shared with providers (defined here as hospitals) who are invited to engage in improvement projects.

Participants in improvement projects range from one to several hundred providers. Facilities which collaborate with the PROs in an improvement project agree on a specified course of action to make the improvement, such as changes in protocols or treatment plans. Some facilities are able to make improvements on their own, but others may request that the PRO assist them with advice, tools, or technical expertise.

After improved processes have been adopted, PROs monitor improvements to determine the extent of the improvement. Since improvement is continuous, ongoing and periodic monitoring ensures that improvements are maintained.

Quality improvement projects in health care facilities typically involve disease processes, conditions, or procedures which are both prevalent and costly. Focusing on quality of care concerns -- reducing risk of complications in hospitals, preventing unnecessary procedures and promoting preventive care -- the health care facility improvement projects save money. The dollar savings are the incidental by-product of the improved care through quality improvement initiatives such as prevented admissions, reduced length of hospitalization, avoided surgical procedures and improved health status.

Quality Improvement Case Studies -- Improving Care and Saving Money

Given that the mission of HCQIP is to promote the quality, effectiveness, efficiency and economy of services to Medicare beneficiaries, the message is simple and compelling: **quality saves money**. Although HCQIP has been in existence for a relatively short period of time, the program shows great promise in documented improved quality of care and cost savings to beneficiaries, providers, and the Medicare program.

To illustrate the scope of HCQIP improvement efforts underway, many projects are not confined to individual states but are replicated in other locales, enhancing their impact across the nation. In addition, several PROs work together on multi-state projects, sharing methods and experiences, such as the twelve Rocky Mountain states which work to improve care for heart attack patients in 175 small rural facilities.

Following are a few case examples of improvement projects where providers have actively identified opportunities for improvement. At this early stage of the HCQIP program, we assume, Mr. Chairman, that participating hospitals will carry out and complete their self-generated action plans, leading to the desired benefits of quality improvement and cost savings. Currently, over 400 individual quality improvement projects are being implemented and are effecting real improvements in the community.

Case Study #1: Reducing Unnecessary Prostate Surgery. In the United States, prostate cancer affects about 30 percent of men over age 50. Since prostate cancer is slow to grow, most men die of other causes and the risk of the operation and its side effects -- impotence, incontinence, urethral stricture and death -- can outweigh the value of surgery itself. In fact, literature suggests that men over 70 experience little benefit from the procedure, that the option for surgery should be the exception rather than the rule, and that surgery is not justified at all in men older than 75.

Nevertheless, data show the procedure has grown rapidly among the Medicare population. Several PROs now are using guidelines produced by the Agency for Health Care Policy and Research (AHCPR) to educate patients and providers about viable alternatives to prostate surgery, including watchful waiting and radiation therapy. Preliminary data from one PRO study show a 75 percent reduction in radical prostatectomy for men in this age group after provider education was delivered. This drop in surgery has resulted in Medicare program savings of more than $1.3 million by the five collaborating hospitals and an increased quality of life for those patients. If all hospitals in the state were to become involved in this improvement opportunity, $2,621,160 per year could be saved.

Four additional PROs collaborating on a similar prostatectomy project estimate cost savings for 1993-1994 as ranging from $5.6 to $13.5 million, for a combined savings total of $36.8 million. If implemented by the entire nation, the projected Medicare savings could total over $1.7 billion. The movement has begun, as approximately 20 PROs are already implementing this project topic.

Case Study #2: Improving Blood Product Transfusion Practices. The nation's blood supply is at a dangerously low level and hospitals have been faced with the prospect of running out of blood products. Moreover, existing practices for reserving blood render it useless to other patients in an emergency. While this practice guarantees availability, usually only half of the reserved blood is actually used. By implementing minimal changes in the way blood is ordered and tested, one PRO helped hospitals to improve quality by maintaining a readily available blood supply and eliminating waste. The project has the potential to save as much as $700,000 annually if all hospitals in that state participate.

In addition to issues in securing blood, research has shown that across the nation blood components are being used in surgery even though patients may not need them. Unnecessary use of blood components increases the risk of allergic reactions and adverse events (such as transmission of infectious diseases like AIDS and hepatitis), results in a lack of precious blood resources, and leads to higher health care costs associated with complications. Reducing inappropriate blood use among 10 hospitals in one state could lead to an estimated savings of $256,065 to $4.1 million, according to that state's PRO.

Another PRO investigated the administration of platelets, a blood component, for Medicare patients in their state and discovered that the cost of platelet overutilization for six providers equaled $23,050 a year. The PRO educated physicians with regard to the College of American Pathologists' guidelines which recommend gauging platelet transfusion by patient weight. This improvement project reduces the waste of blood platelets and preserves inventory levels so other patients in need will have platelets available.

Improving the retention and administration of blood products will enhance quality of care for all patients by lowering the potential risk that comes with unnecessary transfusions and lessening the demand for a valuable resource. Currently, approximately 36 PROs are conducting blood conservation improvement projects.

Case Study #3: Promoting Appropriate Treatment of Heart Attacks. Using Medicare mortality data, several PROs are conducting projects on the appropriate use of thrombolytics (including aspirin) in patients admitted for heart attacks, one of the leading causes of death in the United States. Pattern analysis reveals that a significant number of patients are eligible for thrombolytic therapy but either do not receive thrombolytics at all, or if so, do not receive them in a timely fashion.

Guidelines published by the American College of Cardiology advocate the appropriate administration and timing of thrombolytic therapy. By promoting these guidelines, one PRO found that the cost for a heart attack episode dropped an average of $420 per patient stay and that the length of stay decreased by three days, all due to improved treatment as a result of their intervention. Another PRO estimates that nearly $2 million could be saved if improved management of thrombolytics were to prevent recurrent admissions by as little as 10 percent.

At present, approximately 21 PROs are pursuing projects on the appropriate use of thrombolytic therapy. These projects are one aspect of the larger cooperative cardiovascular program being implemented by the HCFA.

Case Study #4: Preventing Pressure Ulcers. Pressure ulcers are a serious national health problem that affect at least 1.7 million patients with an associated health care cost of more than $1.3 million. This condition can be difficult to treat and leads to unnecessary pain, increased risk of infection, intensified nursing care, extended hospital stays and higher patient care costs. Prompt and effective treatment, however, can minimize these effects and speed recovery.

Statistics reveal the costs of treating pressure ulcers as 2.5 times as much as prevention. Treating a single ulcer can range from $4,000 to $40,000. Pressure ulcers can be minimized by educating providers and promoting systematic adherence to preventive procedures, such as the guidelines published by AHCPR. Appropriate guideline implementation is estimated to reduce the cost of pressure ulcer treatment by as much as $40 million nationally. Expected savings from prevented pressure ulcer improvement projects in two small states equal $940,000. Currently, approximately 11 PROs are pursuing this project topic.

Case Study #5: Improving Heart Catheterization Practices. Heart catheterization, a procedure examining the arteries surrounding the heart, is a standard procedure in patients with coronary artery disease, the major underlying cause of death in the United States today. Although the procedure has historically been performed on both the right and left sides of the heart, the American College of Cardiology and the American Heart Association recently published guidelines stating that without specific indication, routine right heart catheterization is unnecessary. According to the guidelines, a cardiologist should neither provide nor seek compensation for catheterization services known to be unnecessary. Current review of Medicare data by several PROs shows that cardiac surgeons routinely examine both sides of the heart while preparing a patient for catheterizations, whether or not the suspected problem relates to both sides of the heart.

One large PRO found that many hospitals had no criteria for performing right heart catheterizations and that individual cardiologists appeared to make their own decisions. Indeed, many hospitals seemingly performed the procedure as training for their residents. After a series of provider meetings and intensive educational efforts, re-evaluation of data before and after the education found a sharp reduction in frequency of right heart catheterizations, resulting in less risk to patients and a savings of approximately $7.7 million per year. Approximately 16 PROs are now involved in this improvement opportunity.

Case Study #6: Preventing Strokes. Several PROs are examining the use of anticoagulants in patients hospitalized with a rapid irregular heart rate, also known as atrial fibrillation. Anticoagulants are recommended to prevent blood clots -- which in turn can result in strokes -- in patients with this condition, according to a consensus panel of the National Stroke Association, guidelines produced by the American Heart Association and others.

Improvement projects underway reveal that significant numbers of patients with chronic atrial fibrillation are not being given anticoagulants, however. Strokes impact quality of care by increasing the potential loss of life and the use of long term care facilities and pharmaceuticals; reducing quality of life, life expectancy, and family stability; and affecting the ability of the elderly to live independently. As a complication, strokes -- one of the leading

causes of death among the adult population -- can generate thousands of additional Medicare dollars per patient stay, not to mention the costs of rehabilitation, long term care and death.

Simply educating providers that anticoagulants should be considered in the absence of contraindications results in improvements in quality of life while diminishing the incidence of costly strokes. For one PRO, combined savings from two small state projects are estimated at over $1 million. At another, larger PRO, direct cost estimates as a result of reducing stroke admissions -- thanks to increased appropriate use of anticoagulants at only 19 hospitals -- ranged from $1.1 to $4.8 million in Medicare program savings. At present, approximately 20 PROs are implementing this improvement opportunity.

Case Study #7: Preventing Lower Extremity Surgery Complications. Pulmonary Embolus (PE), a blood clot in the lung associated with Deep Vein Thrombosis (DVT) -- a blood clot of the lower extremity -- is a frequent but largely preventable complication of any operation of the lower extremity, such as the knee or hip. In fact, PE is the single most common cause of preventable hospital-associated death.

Published guidelines show effective methods for preventing DVT/PE, and illustrate that patients who do not receive this care are unnecessarily exposed to the risk of serious complications. Pattern analysis by PROs uncovered significant numbers of lower extremity surgery where patients were not receiving appropriate monitoring and/or preventive therapy during admissions. Provider education emphasizes appropriate preventions, according to published guidelines, in patients undergoing these operations.

In one state, the average, annual Medicare charge for treating a patient for lower extremity complications was approximately $13,395. This figure strongly suggests that considerable cost savings will result as medically appropriate steps to prevent DVT/PE are implemented. Currently, approximately 11 PROs are conducting variations on this improvement project.

Beneficiary Education Initiatives

An important goal of HCQIP is for PROs to communicate with beneficiaries and providers to promote informed health choices. Recognizing the value of involving beneficiaries in the health care decision-making process, the Medicare program has made beneficiary education an integral component of its benefit structure. In this arena, PROs are making data available to providers and beneficiaries on health promotion, treatment options, and disease prevention.

Services which have proven potential for illness prevention (i.e., influenza and pneumonia vaccination) and early cancer detection (i.e., screening mammography) have been greatly underutilized by the Medicare population. Information about treatment options likewise targets two very common conditions in the Medicare population: breast cancer and prostate cancer.

Our approaches to disseminating information to Medicare beneficiaries vary. Several are being pilot-tested. They usually involve networking with consumer groups, the media, information hotlines, or organizations that share the PRO's interest in health promotion.

Beneficiary Education Case Studies

Case Study # 8: Influenza and Pneumonia Vaccination. Although many seniors are aware that the flu shot prevents illness, only about one third of all eligible persons obtain the shot. Both flu shots and pneumonia vaccinations are a covered Medicare benefit at no cost to the beneficiary. Individuals who are not vaccinated face increased risk of illness resulting in hospitalization and perhaps unnecessary cost to the system.

In one example of a medium sized state, Medicare billing data demonstrated that flu and pneumonia accounted for 7,761 hospitalizations in a one year period. The average length of stay was 9.2 days, with an average cost of $9,685 per stay. The total cost to treat these patients was in excess of $75 million. Individuals with heart and respiratory complications -- in addition to the flu or pneumonia -- cost more that $215 million to treat. In contrast, preventive measures such as the flu vaccine costs Medicare about $7 per shot, and the pneumonia vaccine (effective for approximately 6 years) costs approximately $20 per shot.

PROs mounted campaigns for the first time during the 1994 flu season and are prepared to do so again in anticipation of the 1995 flu season. PROs typically work with state health departments and provider and consumer groups to distribute information -- such as brochures -- in areas where seniors are known to congregate. Public service messages by the media enhance the outreach effort. Such pertinent information allows individuals to make well-informed health decisions.

Screening Mammography. Breast cancer is the most common cancer in women in the United States. Despite strong scientific evidence supporting the effectiveness of screening mammography and the universal recommendation that women 50 years and older undergo routine screening, studies have shown that only about one-third of older women comply. In fact, Mr. Chairman, in some states that rate is even lower. Since early detection of breast cancer can save lives and obviate the need for the disfiguring surgical procedures, the campaign to educate women of the benefit of screening mammography is compelling.

Treatment Alternatives. Breast cancer poses a serious threat to older women. Data has shown that women are not aware of their treatment options and are not taking advantage of breast conserving therapy, recommended in the early stage of the disease. We are in a unique position in the community to fill this informational void. Pilot programs are underway in several states to bring information about breast cancer treatment options to Medicare beneficiaries.

Involving patients in decisions about treatment options is a powerful tool in changing physician practice patterns. One PRO discovered this when it distributed an informational brochure about treatment options for prostate cancer. Letters from Medicare beneficiaries to the PRO make it clear that the information has helped many to ask informed questions of their physicians and to opt for the treatments that suit them best. Undoubtedly, the drop in radical surgery in that state was, in part, due to better informed individuals.

Quality Protection

Quality protection is integral to the PRO statute. Various mechanisms are in place through which we perform this obligation, the most prominent of which these are the beneficiaries' appeals, complaint rights, and the analysis of a random sample of medical records. In each case, the PRO determines whether services provided were medically necessary and appropriate; were furnished in the appropriate care setting; Medicare coverage policies were followed and correctly billed by the provider; and, whether the care conformed to acceptable standards of quality.

Beneficiary Complaints. Medicare beneficiaries or their families who are concerned or dissatisfied about the quality of care they received in a hospital or by a physician may request a PRO investigation. We will investigate the complaint and determine whether the care and services meet accepted standards of care.

In the event of a supposed quality of care problem, we will take corrective action. Actions may range from educational efforts with the facility or physician to a recommendation for sanctions submitted to the office of the inspector general in the event of gross and flagrant or substantial violations. This authority -- rarely exercised -- is used only if the hospital or physician is unwilling or unable to comply and when all other avenues have been exhausted.

Beneficiary Appeals. The beneficiary may appeal when the attending physician and the hospital want to discharge the patient and the patient does not agree. While many of these issues are easily resolved by the PRO in cooperation with the hospital and physician, there have been instances of potential harm or risk to the patient, warranting the PRO's intervention.

The beneficiary may also appeal any decision made by the PRO and if dissatisfied with the appeal, may present his case to an administrative law judge.

Random Sample Review. The PROs conduct a review of a random sample totalling approximately 1% of Medicare inpatient records and 3% of ambulatory surgery medical records. This allows for utilization and quality evaluations of physician and facility services. Random sample review reflects a minimum compliance monitoring of each Medicare provider, including prospective payment system (PPS) and non-PPS hospitals, and ambulatory surgery centers. A minimum of home health and long term care services is also included.

We scrutinize these cases to determine whether the services provided were appropriate and met Medicare payment guidelines and acceptable standards of care. In the event of a possible violation, the PRO may conduct further investigation of the provider to determine what action to take. Initial efforts stress an educational approach, but if the provider is either unable or unwilling to correct the problem, the PRO may recommend a sanction, including a civil monetary penalty or an exclusion from Medicare for a specified time. It should be noted that the sanction authority is only utilized as a last resort.

QUALITY IMPROVEMENT IN MANAGED CARE

Since the early 1980's, the Medicare program has encouraged HMOs to provide coverage to enrolled beneficiaries in return for fixed prepaid premiums (Mathematica). Under the aegis of the Tax Equity and Fiscal Responsibility Act (TEFRA), the Medicare program

initiated a Medicare risk program which allows HMOs to assume responsibility for providing all Medicare-covered services to beneficiaries in return for a capitated payment.

In addition to its primary goal of reducing costs, the risk program continues to embody two objectives: to provide more efficient health care *while maintaining or improving the quality of care*, and to give Medicare beneficiaries access to the same range of choices younger individuals enjoy.

Mr. Chairman, the growth of Medicare managed care is an inevitable result of the managed care revolution sweeping the private sector. There are both risks and benefits to patient care associated with prepaid delivery systems that suggest the need to strike an appropriate balance between external monitoring and reliance on the unique internal quality assurance and improvement capabilities of integrated health plans. In this regard, AMPRA supports the resolve of the Health Care Financing Administration to redesign PRO oversight of Medicare managed care to fit the model of the Health Care Quality Improvement Program.

Because PRO quality improvement projects rely on analysis of data which are readily available on the fee-for-service side -- *but lacking on the managed care side* -- a different method is called for in those care settings. The Medicare program has encouraged PROs to come forward with their recommendations for alternative methods. Pilot projects are underway in a number of states.

Quality Improvement in Managed Care Case Studies

Quality improvement efforts in managed care follow the same principle as in the fee-for-service environment, with the PRO and the plan jointly entering into quality improvement activities.

One case study involves a state in which 25 percent of the Medicare population receive health care through six "at risk" managed care plans. Less than a year ago, these plans formed a continuing quality relationship with the PRO. This relationship is based on two elements. First, there is continuing interaction between the plans and the PRO, both collectively and individually, on quality issues. Second, the PRO collects data from individual HMOs, compiles it, and then feeds it back to the plans, thereby enabling each plan to compare its own performance to that of all plans in the aggregate. Plans that choose to do so are free to share their data with other plans.

Case Study #1: Mammography Screening and Follow-up. A PRO recently focused on one plan's mammography process in an attempt to improve preventive care breast services in the state. Specifically, the project addressed:

- the degree of compliance with the HMO's mammography screening standard (one per enroll every two years);
- the timeliness in notifying the patient of the mammogram's result;
- the timeliness of follow-up treatment for an abnormal mammogram; and
- the relationship of certain selected patient and provider characteristics to screening compliance, and timeliness of notification and follow-up.

What makes this study unique from other initiatives in this area is that it addresses the critical issues of whether appropriate follow-up occurred after the mammogram (especially if the result was abnormal) and whether the follow-up was in a timely manner.

Since the HMO had no standards in place regarding the timeliness issue, the PRO, in partnership with the plan, agreed on two standards for timeliness: time between administration of the mammogram and patient notification of the results should occur within 14 days; and, follow-up between an abnormal mammogram and resulting biopsy should occur within 42 days after the patient has been informed of an abnormal result.

The study revealed that 40 percent of mammograms had no documented notification date in the medical record. Almost one third (n=120) of the mammograms without a documented notification result had an abnormal reading. Younger women with an abnormal reading were more likely to have no documented notification of results than were women at least 75 years old. Despite this lack of documentation, 69 percent of the 120 abnormal mammograms were followed by surgery.

This study demonstrates great variation in the documentation and timeliness of notification of abnormal mammography results. Even greater variability was encountered in the six independent practice associations (IPAs) (within this managed care plan), especially in timeliness to follow-up surgery. On average, surgery in the plans was performed one week later than the mean of 30 days. The study also revealed that 23 percent of the patients with abnormal mammograms did not have follow-up surgery.

The quality improvement plan resulting from the study included several mass educational efforts directed at providers and enrollees to increase mammography screening. The effectiveness of this effort is currently being evaluated. Other improvements targeted were documentation of patient notification and overall provider practice relative to breast cancer screening, notification and follow-up surgery.

Other ongoing activities PROs perform in conjunction with risk contracts include:

- quarterly monitoring of individual beneficiary complaint logs;
- performing reviews of unexpected deaths;
- serving as a catalyst in improving preventive care services (i.e. mammography);
- comparatively reviewing the management of major diseases (i.e. diabetes); and
- collaborating with plans and providers in four problem areas -- surgical replacement of hips and knees, incontinence, polypharmacy, and depression -- by encouraging adherence to guidelines on the management of care.

Case Study #2: Cataract Surgery. Medicare beneficiaries enrolled in HMOs in a state with a large Medicare population now have greater access to cataract surgery. Recently, the PRO began a statewide quality improvement project focused on cataract surgery.

A beneficiary had called to complain that his HMO denied him cataract surgery. When the PRO reviewed the health plan's pre-certification criteria, it found that it was radically different from criteria used in the fee-for-service sector and from the accepted AHCPR practice guidelines on cataract surgery.

Specifically, the HMO developed indications for cataract surgery based on a patient's visual acuity level were substantially different from the AHCPR guideline recommendation. The PRO notified the HMO of the discrepancy, and the HMO adopted the AHCPR guideline. Taking it a step further, the PRO requested cataract surgery criteria from all the Medicare HMOs in the state and discovered similar problems. To date, three HMOs covering over 250,000 Medicare beneficiaries have changed their criteria to conform to the accepted guidelines.

This study illustrates the benefits of PRO monitoring of beneficiary complaints. This helps the HMOs to develop improvement strategies. Improvements, in turn, generate satisfied beneficiaries preventing "plan hopping" which can result in savings for the Medicare program.

The HCFA Managed Care Pilot Project. As we have already heard this morning, the Delmarva Foundation for Medical Care (Delmarva) -- the PRO for Maryland and the District of Columbia -- together with Harvard University is developing a method for assessing the care of Medicare beneficiaries who receive their health care from HMOs and competitive medical plans (CMPs). Using performance measures developed in a previous Delmarva pilot project -- Developing and Evaluating Methods to Promote Ambulatory Care Quality (DEMPAQ) -- as well as HEDIS 2.0. Delmarva has outlined a set of three "core" measures and 17 measures in one diagnostic-specific module -- diabetes mellitus. A related project, the Ambulatory Quality Improvement Project (AQIP), is developing measures for fee-for-service ambulatory care that will use the same outcome indicators for diabetes. This will, in turn, allow HCFA to make meaningful comparisons between the outcomes of treatment for managed care and fee-for-service patients with diabetes. AMPRA supports immediate pilot testing of these measures prior to national implementation.

The Need for Encounter Data. As noted above, Medicare does not have access to uniform patient encounter data of services provided to its at risk populations. These data are available in the fee-for-service sector and are used to profile and analyze patient care data to identify opportunities for improvement. AMPRA supports HCFA's development of a minimum patient encounter data set that would allow the Medicare program to profile and analyze the care received by its HMO/CMP enrollees and facilitate the identification of improvement opportunities.

CONCLUSION

The HCQIP program is an exciting and dynamic new partnership among beneficiaries, providers, PROs and HCFA to improve the quality of care for Medicare beneficiaries. While still in an early stage of evolution, HCQIP has already demonstrated great potential. Past administrative burdens and regulatory controls have been significantly curtailed, reducing hassles and costs for Medicare providers and allowing resources to be concentrated on enhancing patient care.

Physicians hospitals, and health plans have -- with increased enthusiasm and commitment -- adopted established practice guidelines and protocols that will lead to improved

patient outcomes. Beneficiary education programs have been established to increase choices and the patient's involvement in treatment decisions. Finally, HCQIP has already documented that improved quality of care results in cost savings, for both the Medicare program and providers, from needless procedures averted, to resources better utilized and alternative treatments pursued.

In the last decade, there have been tremendous advances in building the science of quality measurement. There is scant evidence, however, that we have been able to translate practice guidelines, outcomes research, and performance measures into sustained changes in practice behaviors and health care processes. The PROs have demonstrated a unique competency in facilitating and integrating quality measurement concepts and tools at the local physician, hospital, and health plan level through HCQIP. This competency, in turn, has led to measurable change and improvement in health care practices. In addition, the PROs have successfully demonstrated the ability to transport these changes throughout an entire state, across state lines (via multi-state projects), and on a national level.

Mr. Chairman, we appreciate the opportunity to testify and look forward to working with the subcommittee on designing strategies for protecting and improving the quality of health care for all Americans. Thank you.

Chairman THOMAS. I thank the panel very much.

Mr. Ensign.

Mr. ENSIGN. Dr. O'Leary, if you had to structure a quality assurance program for the country, how would the private sector or the public sector fit in structure-wise? In simple terms, where would the funding come in?

Dr. O'LEARY. I think the basic expertise and infrastructure to do this lies in the private sector and I think that is where it belongs. We have a long track record to demonstrate that we do it well. There is also, though, the issue of the social contract between the Federal Government and the public and whether the Federal Government wants to play a role in providing assurances to the public that there is effective quality oversight.

That requires, in my view, at least a minimum of responsibility to assure that there is some agreement on what the standards and performance measures are going to be. I see that as more of a Bureau of Standards responsibility, as opposed to a Health Care Financing Administration regulatory responsibility. Somebody has to set the gold standard to establish comparability, and that, in my view, is something that we have seen work out more or less well in the past with other relationships and is something that is probably needed today.

Absent that, you will have competing evaluators out there; that is not horrible, but it does create some confusion among those who are being evaluated. I think that there is a potential partnership here that can capitalize on the resources and commitment of the private sector and assure accountability on the part of the Federal Government without any intrusive behaviors.

Dr. BEE. I think there are two components to quality evaluation and monitoring over a period of time. Dr. O'Leary and Ms. O'Kane represent the accreditation side, which sets the minimum standards for entry into the game. I think someone has to monitor how the game is being played and I think that that is best done by the private sector.

The PROs are private sector organizations that have contracts with Medicare, Medicaid and in many cases industry and insurers to do just that job. We do not believe that a regulatory approach is very helpful. Obviously, there are times when you have to say to a particular person do not do that anymore, but that is a very small part of the process of quality improvement.

The exciting thing is getting the data that so many of you mentioned this morning, an essential piece in our ability to find out what is going on. Until we find out what is going on, it is very hard to decide what needs to be changed. For us, quality means looking at what is going on, working with the people who are doing the activity, helping them decide what needs to be improved and then helping them monitor, assess, and do it all over again.

The quality improvement tools that have been so successful in industry are definitely applicable to health care and we think that we are doing a pretty good job of beginning the process of evolving the health care system as a whole and continuous quality improvement.

Mr. ENSIGN. You mention 1986 when a lot of this started. How long do you foresee this taking—another 9 years, 20 years, before we feel like we have a fairly decent system in place?

Dr. BEE. We are just beginning to find out how effective the system is. Those of us who get a chance to work with physicians and hospitals find them to be very excited about the prospect of actually having information about what they do. Most doctors have labored their whole professional lives with only a dim idea of what they did, how much of it they did and not a very good idea about the long-term outcomes of it. We are excited to get that information because we think it will help us do a much better job.

Dr. O'LEARY. I might comment that this is a building block activity. We feel pretty comfortable with the performance-based standards that we are using. I think that would be true for NCQA as well. The area of developing performance measures is a newer art form and one that we are engaged in building over time and learning how to integrate that into our basic accreditation process. Ultimately, we should be driving our evaluation systems on the basis of performance data which will tell us where to focus our evaluation activities.

Ms. O'KANE. I think cars are actually a good analogy. We see a system where issues affecting life and limb like the safety of cars and air pollution are regulated. There is available information for consumers on issues like comfort, ease of handling and durability that are not really life and limb issues.

I think that analogy holds in health care as well. There is a role for regulators to protect the consumer from harm and these regulatory processes have been working successfully, but they set a threshold that is very low.

The kind of processes that we have are aiming much higher. Our accreditation process has set standards that were derived from the most demanding purchasers in the private sector. We do not see our standards as appropriate for regulating market entry, but as doing something that might—especially when a plan meets our standards—replace parts of the regulatory process that are redundant. We have had a lot of successful public-private partnerships and we like the idea of working in partnership with the Federal Government as well.

Mr. ENSIGN. One last comment. I would caution everybody in the process that as we get into this data information process, the government sets something up sometimes once rules are in place, once standards are set, that can stop a whole new way of thinking. We can get into a paradigm. Once the Federal Government is involved, shifting that paradigm can be very difficult.

The instances you brought up with EPA and the Clean Air Act, suggesting that we could make some dramatic advances right now if they were not being halted because of certain paradigms that are being developed. This is the way we do it. We cannot do it any other way. I would make that note of caution. Thank you.

Chairman THOMAS. Mr. Christensen.

Mr. CHRISTENSEN. Thank you, Mr. Chairman. Miss O'Kane, what percent of NCQA's budget is derived from the Federal Government?

Ms. O'KANE. It is a very minuscule percentage. I can get you the numbers. Most of our revenues come from our accreditation activi-

ties which the health plans pay for, and the rest from foundations. We had a small grant from the Medicaid Program to do a technical assistance document for Medicaid HMOs, about $25,000, so it is a minor—

Mr. CHRISTENSEN. Less than 5 percent, less than 1 percent?

Ms. O'KANE. Less than 1 percent.

Dr. O'LEARY. We are probably pretty much in that range. The contracts that we have are for mostly international service. We have a U.S. AID contract, Department of Treasury contract, a Peace Corps contract, but virtually all our revenues come from services we provide to health care organizations, which include Federal organizations like Federal hospitals. Less than 1 percent.

Dr. BEE. I cannot tell you with much precision because our members vary from those who do virtually no business except under their Medicare contract, to those for whom the Medicare business is less than half of their gross income. The PRO program was a congressionally mandated program to protect Medicare beneficiaries and it is performed under contract with HCFA, so that all of those dollars come out of the Medicare trust fund.

Mr. CHRISTENSEN. My reason for asking is, with all due respect, Dr. Brook requested another $100 million to study, in my opinion, what you are doing pretty much already; is that correct? I guess I want to ask Ms. O'Kane, it is my understanding that HMOs join your organization voluntarily; is that correct?

Ms. O'KANE. They do not join our organization. They pay to become accredited. It is a voluntary accreditation program. It is usually responding to a purchaser mandate, in some cases a State mandate.

Mr. CHRISTENSEN. Why would a company voluntarily submit to such a stringent standard that your organization runs them through as far as analyses, and is there a competitive advantage to having your accreditation versus say some others?

Ms. O'KANE. I think that we have managed to make a name for ourselves among the corporate purchasers who are trying to decide among various managed-care options. I think from the point of view of the health plans, they believe that this accreditation distinguishes them in the marketplace and gives them an edge. That is why they have really come forward.

Mr. CHRISTENSEN. Assuming we do not want a new Federal or State bureaucracy to develop these type of standards, should we try to keep it in the private sector? I know this is a loaded question, but in terms of—I just really have a real suspect of everything government gets their hands into.

Is there any rationale for the government to be doing this testing, to be looking for this information, to be becoming more informed in this area? Is there any rationale why we cannot keep this in the private sector?

I was impressed with Dr. Brook's rationale. But, I am trying to see if there is something in it that I am missing—

Ms. O'KANE. I think there is an important role of the Federal Government in terms of being a purchaser of services for the Medicare and the Medicaid population to be very demanding about the kinds of quality oversight processes that they are counting on to assure the quality of care that those beneficiaries receive. I

think that organizations in the private sector, like ours, need the help of purchasers and the government to keep us honest, by telling us the kind of information they want to have and making sure our processes are working the right way.

When we do reviews for States, sometimes State people come with us on the reviews so that they can have assurances that the process is working well. I think that is an important role. I do think that the government can work in partnership with us and that they need to be a presence, but that much of the work can actually be done very effectively in the private sector.

Mr. CHRISTENSEN. Mr. Chairman, could I have Dr. Bee and Dr. O'Leary also answer that question?

Dr. BEE. I will be happy to send you a 1-page comment by Dr. John Wennberg which explains why very large patient samples are necessary to learn meaningful information. A single HMO with only 1.5 million members such as mine, there are numerous health care questions that cannot be answered even with that large a patient sample. We do need to have some way of collecting very large samples, for example, the HCFA project called the CCP, Cooperative Cardialvascular Project, in which an enormous sample of patients over 65 with myocardial infarction will be studied and from that we will learn what works and what does not. I think that is one reason we need a Federal mandate in some areas.

The Federal Government is also the largest purchaser of health care services in this country. The purchasers of health care must have some responsibility for the payment for the quality monitoring. It is a part of the health care premiums and the government puts in the premiums. They should be a part of the cost of monitoring.

Dr. O'LEARY. I think a lot of this boils down to whether we want to have good information available for consumer choice. If you do, I have to tell you that the hopper is anything but full in terms of having good standardized measures and good risk adjustment systems to account for differences in patient populations. A lot of that work is coming out of AHCPR, the Agency for Health Care Policy and Research right now.

These are important roles—to help accelerate the process to develop good measurement systems and to establish some modicum of standardization. If we decide that we do not want report cards or consumer choice information, then those arguments, I think, in a sense disappear. The government is a major purchaser of care in this system and in that sense has some accountability in its social contract with the public. I would opt on the side of saying that, yes, there is a place for investment but not for any significant regulatory intrusion.

Mr. CHRISTENSEN. Thank you.

Chairman THOMAS. My friend is concerned that the government model will be the DOD in terms of standardization—I do share that concern. However, the other problem that we have is another common criticism of government and we ask do you have a product, when will you have a product? When can we use it? The private sector base is, we got something that is kind of OK.

I was looking at this article from Business and Health entitled, "HEDIS: Almost Ready for Prime Time." You have gone to 2, 2.5,

going to go to 3.0. I assume 5 years from now you will be at 7.5 or a completely rethought structure.

What we like about what you are doing is just do it. We will still be waiting for phase 1. So my questions read to how can you help us?

All of you were very cautionary about the size of the purchasing agent that we represent here in terms of health care, and we are going to play a major role, but I want to focus on the database which is obviously critical. Could Medicare play some kind of a helpful role in establishing criteria or uniformity for the collection of data? Or two, do we really need a complete national uniformity on the database or could we operate with a regional structure? Anyone?

Ms. O'KANE. Since you have mentioned HEDIS and 7.5, I want to jump in. There is an issue with people in the quality field. The issue is that the best is sometimes the enemy of the good and I think that we tie ourselves in knots sometimes to say, well, this isn't really the end point of where we need to be.

In doing that, we undermine the value of what we have done and I think that may be the case with HEDIS. I think HEDIS provides us with a lot of valuable information. We have a lot more information on health plan performance today than we did 3 or 4 years ago and I think we will move ahead. The information from our accreditation program also provides a lot of useful information.

Dr. O'LEARY. I would plead to not standardize the database, please. That is not a good government role. I think by contrast what would be helpful is some agreement on the criteria against which we will determine whether a measure is any good or not.

Another thing that would be useful is some agreement on good risk adjustment systems. These are resource kinds of issues that help the private sector come together more quickly in delivering the goods that everyone wants.

Chairman THOMAS. You are asking for decisions on the part of the government that is akin to making decisions on who gets the organ—whether or not—you are dealing with qualitative decisions in terms of what is good or not. One of the ways that we are going to have to be able to make a decision on what is good or not is to have a solid database from which to make those decisions. Are we going to rely on the private sector database or have confidence about the base to make the decisions about what is good?

Dr. BEE. One of the roles the government has is to arrange the world in such a way that we can do the things that need to be done without being regulated into them. We do not want uniform standards for data collection cast in stone because we are not sure which ones are useful. It needs to be a continuously improving process and government is not very good at that.

It is important as we talk about managed care that we realize that the vast majority of managed care in this country is not delivered in a nice Kaiser clinic somewhere. We have a million and a half members in our company and only 23 percent of them are cared for in a staff model clinic. The rest are seen in private doctor offices that have to contend with up to 23 other HMO contracts in Southern California, each of whom may want to pull a sample of

charts and evaluate the indication. When I was a practicing physician, that was kind of an aggravation.

One of the things the government needs to do is, to help do whatever it takes to make the game more efficient, so that we can collaborate, perhaps only one team has to come to my office to collect the information once a year for all health plans. These are areas of improvement that will reduce aggravation to practicing physicians and certainly the cost of doing business.

Chairman THOMAS. Hopefully, the Federal Government could be a coordinator and facilitator. That was rather frustrating in the 103d Congress. We did nothing in the area of uniform malpractice or insurance structure to assist the progress that was being made. At the very least, we hope we can play that sort of role.

Let me ask another question. Ms. O'Kane, since you are dealing with private sector folk, to what extent would it be helpful to focus on or emphasize on a more seamless approach to moving people from the workplace into a retirement health structure? Since the workplace is more and more becoming a managed-care world, we could create a seamless structure where employers who now pick up medigap on some retirees and others, they could be the basis for evaluation.

Do you have any program, thrust, interest, direction in looking at employers dealing with retired folk and what seems to be working?

Ms. O'KANE. Yes. This is an area of interest, but I do not have much light to shed in terms of our direct experience. I think Bruce Vladeck mentioned that we have been having discussions with HCFA about doing some Medicare HEDIS. Part of that, is to bring some of the employers in; employers who have large retiree populations would be key players.

On the issue of standardization, I sort of ducked on the second part of your question inadvertently. I think it is important to say that we have achieved a real degree of success with standardization of performance measures already because there is such a demand for it among the large corporate purchasers. They find that it is really impossible to make comparisons among plans in order to do value purchasing if they do not have standardized information. However, that does not mean that there should not be local ability to ask questions that might be relevant to the local population, and so forth.

Chairman THOMAS. My concern is that as we move more into the question of managed care for a senior population, that I want to make sure that we have an anchor to the real world and that it isn't just government bureaucracy setting up standards and structures to make decisions which attempt to capture reality in a bottle, which is one of the bigger problems I have right now with Medicare, and the real world is rapidly leaving us and we are not tied to it more and more. My concern is how we transition.

Ms. O'KANE. That is an area where we can point with pride at what we have done in terms of being able to broker discussions between the stakeholders in managed care organizations and the managed-care organizations. We are trying to come to a common definition of what do we mean by quality and measuring it in a very specific way.

Dr. O'LEARY. The Joint Commission has pretty extensive home care and long-term care accreditation programs, and those are stand-alone activities, but those are also component to our health care network accreditation program as well. So, there are mechanisms already in place to look at that population.

Dr. BEE. The Health Care Quality Improvement Program that Medicare has instituted for the PROs mandates that we look at care in all sites, including the home care, office care, and so forth, an expanding area. I know Mr. Christensen is concerned that we not throw good money after previously spent money in looking at these issues.

Medicare has invested a couple of billion dollars in review over the last 10 years and has built a structure of organizations that are capable of doing this kind of analysis, this feedback loop, the retraining of physicians hospitals and the community.

The PROs are extremely active in dealing with the beneficiary community to teach them how to use the system, how to prevent disease and most important, how to choose wisely between various treatment alternatives so that their true needs are met.

Chairman THOMAS. I thank the panel. I know you will continue to just do it—

Ms. O'KANE. Might I comment? I want to second Dr. O'Leary's plea for the idea that there really is a need for more development in the measurement area and that that is something that our organizations alone cannot fund. We think that there is an important role and that the government has played a very constructive role in that area in the past and we hope will continue to do so in the future.

Chairman THOMAS. To provide you resources to assist you in going forward over the next several years, hopefully you will provide us with an ability to not commit some of the mistakes you have made, and to not go off in directions that are not useful.

Thank you very much for the private sector going ahead and getting the job done. Thank you very much.

The last panel, Dr. John Nelson, a member of the board of trustees, American Medical Association; Gail Warden, president, chief executive officer, Henry Ford Health System on behalf of the American Hospital Association; William J. Osheroff, M.D., vice president, medical director, PacifiCare of California on behalf of the Group Health Association of America, and Beatrice Braun, board member, American Association of Retired Persons.

Your written statements will be made part of the record without objection. You may address the Subcommittee for 5 minutes.

Dr. Nelson.

STATEMENT OF JOHN C. NELSON, M.D., MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Dr. NELSON. Thank you, Mr. Chairman. I am John C. Nelson. I am a practicing obstetrician and gynecologist in Salt Lake City, Utah, where I also serve as deputy director of the Utah Department of Health. I was vice president of UPRO, the Utah's Peer Review Organization, for 5 1/2 years. Currently, I am on the board of trustees of the AMA, American Medical Association. On

behalf of the AMA, I would like to thank you for allowing us to testify.

The AMA applauds your leadership in examining Medicare and private sector health care quality assurance. My remarks today will focus on key aspects of these Medicare PRO programs.

In 1992, the Health Care Financing Administration unveiled the Health Care Quality Improvement Initiative and drafted the PRO Fourth Scope of Work. My own PRO in Utah and the AMA were instrumental in helping to conceptualize the Fourth Scope of Work to move away from a punitive approach and toward an educational approach. This scope of work fosters quality improvement.

Traditional quality assurance is punitive, guarantees the status quo and stifles innovation. However, quality improvement is educational, innovative and adds value to the health care which patients receive.

The AMA was pleased that significant improvements were made to the Fourth Scope of Work due to the input of practicing physicians. We were also pleased at HCFA's responsiveness to our recommendations. The Fourth Scope of Work has resulted in an increased level of collaberation among PROs, hospitals, and physicians on quality improvement efforts. In 1994, the initiative evolved into the current Health Care Quality Improvement Program.

HCFA announced last year that the data collection system that was under development to review the quality of hospital care provided to Medicare patients would be replaced with the MQIS, Medicare quality indicator system.

MQIS is a system of indicators used to measure the quality of care provided to Medicare patients.

The real concern of the AMA has always been the quality of care that our patients receive and the relationship between patients and the physicians who care for and about them.

We have appreciated the opportunity to work with HCFA to ensure quality improvement. The AMA has historically sought to play an active role in any public or private sector efforts to develop medical quality and performance standards. We have a critical interest in monitoring HCFA's refinement of the MQIS. It is essential that practicing physicians remain involved in the evaluation and implementation of these Medicare quality indicators.

Most efforts to review the quality of care that Medicare beneficiaries receive have been focused in the hospital setting. It should be noted that numerous, if not most, patient encounters occur in the physician's office and other ambulatory settings. Congress enacted legislation in 1986 requiring the program to develop methods for reviewing these ambulatory settings. To meet this requirement, HCFA developed the ACQIP, ambulatory care quality improvement project. ACQIP is a quality improvement approach to reviewing care provided in physicians' offices.

The two studies involved PROs in the States of Alabama, Iowa, and Maryland. The study is initially focusing on testing quality indicators for diabetes and volunteer physicians are being used to test the quality indicators developed. Inasmuch as this methodology is experimental, the AMA believes that any type of physician office review must be targeted or done on a pilot basis. It is crucial

that such review be nondisruptive to patients and allow for the smooth operation of office procedures. The AMA supports the cautious approach that HCFA has taken. We believe that projects such as ACQIP that focus on quality of care will prove to be useful. We caution, however, that benefits of ambulatory review as well as any review should be used to encourage and improve innovation and quality; not divert a physicians' ability to care for patients. HCFA currently is in the process of developing the PRO Fifth Scope of Work for the 3 years between 1996 and 1999. HCFA plans to continue to emphasize its educational and nonpunitive approach that was initiated under the Fourth Scope of Work.

The AMA is pleased that HCFA has actively sought the involvement of physicians in several national projects. However, concerns have arisen in several locations over the basis on which PROs select quality improvement projects. We encourage PROs to include State medical associations, specialty societies, and the local medical community to a greater extent.

We discussed our concerns with HCFA. We discussed our concerns with HCFA. We understand that a Fifth Scope of Work will require each PRO to choose many of its quality improvement projects from an array that has been selected by HCFA. We hope that such a provision will help to strike an appropriate balance between projects that have demonstrated validity and the need for PROs to have the flexibility to address the quality concerns that are locally based.

Mr. Chairman, it is important to note that some PROs have not historically had a history of positive relationships with physicians or other health care providers. Their traditional quality assurance, or a "bad apple" approach, has in the past created a tension between partnership with physicians and regulation.

Nevertheless, during the past 2 years physicians have reacted in a very positive fashion to refinement in the Medicare PRO program. A public-private partnership is key to developing and implementing a successful quality improvement initiative for our patients. The AMA intends to continue to monitor closely and actively participate in the future direction of this program.

As the Subcommittee continues its efforts to reform the Medicare Program and the current health system, we urge you to use the significant improvements that have been made in this program as an example of potential for positive change. The AMA looks forward to continuing its partnership with you, our patients, the Congress, and the administration to improve the quality of care further. At this point, I would be pleased to respond to any questions that you might have. Thank you very much.

[The prepared statement follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Committee on Ways and Means
Subcommittee on Health
U.S. House of Representatives

RE: Medicare Peer Review Organization (PRO) Program

Presented by John C. Nelson, MD

March 21, 1995

Mr. Chairman and Members of the Subcommittee:

My name is John C. Nelson, MD. On behalf of the American Medical Association (AMA), I would like to thank you for the opportunity to testify before you this morning. I am a practicing obstetrician and gynecologist in Salt Lake City, Utah, and also serve on the Board of Trustees of the AMA. The AMA applauds your leadership in examining the important issues relating to Medicare and private sector health care quality measurement, assurance, and improvement. My remarks today will focus on several aspects of the Medicare Peer Review Organization (PRO) program.

PRO FOURTH SCOPE OF WORK

In 1992, the Health Care Financing Administration (HCFA) unveiled the Health Care Quality Improvement Initiative (HCQII) and drafted the PRO Fourth Scope of Work, which outlined the medical review requirements for PROs beginning April 1, 1993. Under this scope of work, PROs have responsibility for examining variations in the processes, outcomes, and quality of care, and for sharing relevant data gathered with hospitals and physicians. Pursuant to the Fourth Scope of Work, the PRO program experienced a fundamental and positive change in which PRO review was to be based on concepts of continuous quality improvement. The program was redirected away from a punitive approach that addressed individual clinical errors and toward an educational approach in which PROs analyze patterns of care and outcomes and, in turn, share this information with physicians and hospitals to identify potential means to achieve the best success rates in improving outcomes and quality of care. In placing a greater emphasis on physician and provider education, PROs are required to hire a physician to serve as a principal clinical coordinator. The coordinator works directly with local hospital staffs on national and local PRO-initiated cooperative projects.

The AMA worked closely with HCFA in drafting the Fourth Scope of Work. We were pleased that significant improvements were achieved due to the input of practicing physicians and HCFA's responsiveness to our recommendations during the development of the scope of work. For example, under the Fourth Scope of Work, HCFA:

- Eliminated the punitive and highly offensive Quality Intervention Plan point system, with a more educational review process to improve the quality of care to Medicare patients. The objectives of the new process were to identify quality concerns and deficiencies in rendered care; assess the causal relationship between the deficiencies and an adverse outcome; determine the source of quality concerns; and identify physicians, hospitals, and statewide problems on which to focus educational feedback efforts to improve the quality of care;
- Significantly decreased the volume of individual case review in favor of profiling and

pattern analysis;

- Required PROs to request and consider comments from state medical associations when formulating new review criteria, as well as to distribute any revised criteria to the medical community at least thirty days prior to implementation;

- Required that physician reviewers must be licensed in the state where the services under review are performed, have active staff privileges in at least one hospital in the PRO area, be active in practice at least 20 hours per week, and care for Medicare beneficiaries on a routine basis;

- Required that PROs must utilize consultants in active practice in relevant specialties when drafting new review criteria or changing existing criteria; and

- Required PROs -- for the first time -- to allow physicians to request a reconsideration of a final notice of a quality concern determination.

Physicians have had, in large part, a positive reaction to the PRO Fourth Scope of Work. It should be noted that there also has been an increased level of collaboration among PROs, hospitals, and physicians on quality improvement efforts. Hospital and physician complaints regarding PRO review have decreased significantly as well.

In 1994, HCQII evolved into the Health Care Quality Improvement Program (HCQIP). HCFA has stated that the program's mission is to promote the quality, effectiveness, efficiency, and economy of health care services provided to Medicare beneficiaries. In short, the program continues to move away from traditional inspection-based quality control and toward internal quality improvement using pattern analysis. The AMA continues to support the educational, non-punitive redirection of the Medicare PRO program as the program proceeds to evolve.

Medicare Quality Indicator System

The Uniform Clinical Data Set (UCDS) was a data collection and case finding system that had been under development by HCFA since 1988 to review the quality and necessity of hospital inpatient care provided to Medicare beneficiaries. HCFA had originally intended to implement UCDS during the period covered by the Fourth Scope of Work, which ends in 1996. Throughout its development, however, UCDS was plagued by a number of problems, including early results showing that UCDS had a much higher "false positive" quality referral rate than traditional nurse review, and concerns that UCDS and its 1600 data elements would be too costly and cumbersome to implement fully. Accordingly, in 1994, HCFA announced that UCDS would be replaced with the Medicare Quality Indicator System (MQIS), a system of indicators used to measure the quality of care provided to Medicare beneficiaries. The AMA believes that replacement of the UCDS with the MQIS is a positive development.

HCFA has stated that the MQIS will provide a basis from which to design improvement projects, track national trends, and possibly certify institutions for participation in Medicare. HCFA has indicated that projects evolving from MQIS should be able to combine statistical interpretation of Medicare data with effective feedback to the health care community to promote improvements in patient care and outcomes.

HCFA is attempting to develop its indicators based on existing practice parameters developed by the Agency for Health Care Policy and Research and the national medical specialty societies. Last summer, HCFA convened an expert panel to provide feedback on the strategy to establish and implement quality indicators. The AMA was invited to participate in the panel's deliberations, along with representatives from the National Committee for Quality Assurance, the Joint Commission on Accreditation of Healthcare Organizations, the American Medical Peer Review Association, and the Agency for Health Care Policy and Research.

HCFA developed quality indicators for acute myocardial infarction as part of what has become known as the Cooperative Cardiovascular Project (CCP). Based primarily on practice parameters developed by the American College of Cardiology, these quality indicators were tested by PROs in Alabama, Connecticut, Iowa, and Wisconsin, and represent the first MQIS project that will be implemented at a national level by all PROs during 1995. The AMA coordinated periodic meetings of a CCP planning group to oversee the development of these quality indicators. The group included physician researchers, representatives of select national medical specialty societies, and representatives of the hospital, PRO, and beneficiary communities. The medical profession was involved in a consensus process to develop quality indicators based on practice parameters developed by physicians.

The AMA has always sought to play a significant and active role in any public or private sector efforts to develop national medical quality and performance standards. The AMA has a critical interest in monitoring HCFA's ongoing development and refinement of MQIS. It is essential that practicing physicians and physician organizations representing medicine remain involved in the evaluation and implementation of Medicare quality indicators. We will continue to urge national medical specialty societies and state medical associations to use their expertise and resources to help HCFA refine and strengthen these indicators.

Evaluation of PRO Program

HCFA has initiated a strategy for evaluating the effectiveness of the PRO program under the Fourth Scope of Work to provide guidance in the development of an evaluation strategy. HCFA created a workgroup in 1993, composed of representatives from HCFA, the AMA, the American Hospital Association, the American Association of Retired Persons, and the PRO industry. The Institute of Medicine was also asked to establish a committee of health care experts and business and consumer groups to conduct an independent review. The PRO program evaluation plan will attempt to: (1) build a community of individuals and groups committed to improving quality; (2) monitor quality of and access to care; (3) improve quality of and access to care; (4) communicate with beneficiaries and providers to promote informed health choices; (5) protect beneficiaries; and (6) develop an infrastructure conducive to HCFA's evaluation strategy. HCFA intends to complete and issue an evaluation report on the PRO program in September of 1995. The AMA is pleased to be a part of this evaluation process.

AMBULATORY CARE QUALITY IMPROVEMENT PROJECT

In 1986, Congress enacted legislation requiring the program to develop methods for, and to implement review in, ambulatory settings. To meet this requirement, HCFA developed the Ambulatory Care Quality Improvement Project (ACQIP). ACQIP is a multi-PRO cooperative project that began on July 1, 1994. It is the operational follow-up to the research-oriented project known as DEMPAQ, Development and Evaluation of Methods Promoting Ambulatory Care Quality. DEMPAQ focused on education and feedback to physicians based on two review methods -- medical records information and Medicare claims profiling to assess the quality of care provided to Medicare patients in physician offices. Performance measures for DEMPAQ were based on three key principles: quality review rather than utilization review; open development of performance measures versus a "black box" approach; and focus on practice patterns and corresponding feedback versus individual performance errors. Records-based performance measures were based on activities that physicians typically perform during an office visit, and claims performance measures were grouped into three types of profiles: condition-specific, office-practice, and preventive-care services.

ACQIP is a quality improvement approach to reviewing care provided in physician offices. The two year study involves PROs in the states of Alabama, Iowa, and Maryland and is initially focusing on testing quality indicators for diabetes mellitus. Volunteer physicians are being used to test the quality indicators developed. Physicians participating in the project will be provided with their profiles and aggregate data. The participating PROs will also provide education on appropriate care for diabetes to the Medicare beneficiaries in these states.

The AMA believes that any type of physician office review must be targeted and focused. It is crucial that such review be nondisruptive and allow for the smooth operation of office procedures. As a result, the AMA supports the cautious approach that HCFA has taken in attempting to develop an ambulatory review methodology, and the AMA believes that projects such as DEMPAQ and ACQIP that focus on quality of care issues will prove to be useful. While the AMA has been pleased with the improvements in implementation, we have had and continue to have major concerns regarding the benefits of ambulatory review measured against the significant regulatory burdens that would result.

PRO FIFTH SCOPE OF WORK

HCFA is currently in the process of developing the PRO Fifth Scope of Work that would encompass the three year period between 1996 and 1999. Under this scope of work, HCFA plans to continue to emphasize the educational, non-punitive approach that was initiated under the Fourth Scope of Work.

While the AMA is pleased that HCFA has actively sought the involvement of physicians in several national projects, concerns have arisen in several locations over the basis on which PROs select quality improvement projects and the degree to which they involve state medical associations, specialty societies, and the local medical community. The Fourth Scope of Work specifically directs PROs to meet with physician representatives on a regular basis to discuss the concerns of the local medical community and the development of quality improvement projects.

We have discussed physicians' concerns with HCFA, and we understand that the Fifth Scope of Work will require each PRO to choose many of its quality improvement projects from an array that have been selected by HCFA. We hope that such a provision will help to strike an appropriate balance between projects that have demonstrated validity and reliability and the need for PROs to have the flexibility to address quality concerns that are more regionally or locally based. We also continue to advocate to HCFA that PROs must work closely with state medical associations and representatives of local medical communities in the selection and development of educational materials that would be disseminated to Medicare beneficiaries.

The AMA urges both the subcommittee and HCFA to ensure that physicians be directly involved in the ongoing refinement of the PRO Fifth Scope of Work so that the positive movement that has been made in the PRO program during the past two years continues in the future.

FUTURE OF THE PRO PROGRAM

As the Subcommittee considers options to transform the Medicare program and to provide for incremental reforms of the current health system, we would like to underscore the AMA's support for the educational, non-punitive direction of the PRO program and for the opportunity for practicing physicians to provide input into numerous aspects of the program. Physicians must continue to play an active role in any public or private sector effort to develop national medical quality and performance standards.

The AMA urges the Subcommittee to consider the following important principles as a guide in the development and evaluation of any quality and performance standards, if coupled with either Medicare transformation or health system reform efforts. Standards and measures shall:

(1) Have demonstrated validity and reliability;

(2) Reflect current professional knowledge and available medical technologies;

(3) Be linked to health outcomes and/or access to care;

(4) Be representative of the range of health care services commonly provided by those being measured;

(5) Recognize the informational needs of patients and physicians;

(6) Recognize variations in the local and regional health care needs of different patient populations;

(7) Recognize the importance and implications of patient choice and preference;

(8) Recognize and adjust for factors that are not within the direct control of those being measured; and

(9) Respect and enforce patient and physician confidentiality.

In addition, data collection needs related to standards and measures should not result in undue administrative burden for those being measured.

CONCLUSION

PROs have not historically had a history of positive relationships with physicians or health care providers. Their continuing responsibility for protecting beneficiaries has in the past created a tension between partnership and regulation. Nevertheless, during the past two years, physicians have reacted in a very positive fashion to refinement in the Medicare PRO program. A public/private partnership is key to developing and implementing a successful, broad-based quality management initiative. The AMA intends to continue to closely monitor and actively participate in the future direction of this program.

As the Subcommittee continues its efforts to reform the Medicare program, we urge you to use the significant improvements that have been made in the PRO program as an example of the potential for positive change. The AMA looks forward to continuing its participation in a partnership with patients, the Congress, and the Administration to further improve the quality of care.

Chairman THOMAS. Thank you, Dr. Nelson.
Mr. Warden.

STATEMENT OF GAIL WARDEN, PRESIDENT, HENRY FORD HEALTH SYSTEM ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. WARDEN. On behalf of the American Hospital Association, its 5,000 institutional members and 50,000 individual members, I am here today both as chairman of the board of trustees and, of course, as president and chief executive officer of the Henry Ford Health System.

Our organization represents a broad range of institutions ranging from independent community hospitals, to health care systems, to fully integrated provider networks, and also represents organizations like my own which have not only large delivery systems, but large managed-care plans as part of the organization.

We, in almost every case, represent organizations that have a lot of pluralism in terms of the financing of health care. Most of us have some managed care, some have a lot of managed care, and all have some or a lot of fee-for-service patients. We believe that in the environment we are now operating in, intense private sector competition will continue for the immediate future, and a restructuring strategy built on coordinated care represents the best window of opportunity to do better from a quality and patient satisfaction standpoint, and to save money.

I would like to make three important points. First, hospitals and health systems believe a high level of accountability for quality can be achieved and that the Federal Government has a right to expect it. Second, coordinated systems are the foundation for high quality care with much improved cost performance and patient satisfaction. Third, we believe the Medicare Program can learn a lot from what has happened in the private sector in the last few years.

Our organization has a very strong commitment to accountability to our various constituencies and to the public and we believe there are four key factors that relate to that accountability. First, our ability to demonstrate the ability to deliver high quality care. To do that, we believe that there has to be initially a credentialing and licensing activity, there has to be board certification of physicians, there has to be Medicare certification and there has to be a focus on standards needed or coordinated care delivery models that combine inpatient, outpatient and preventive activities under forms of bundled payment, including capitation.

Currently, hospitals and health plans are subject to review by both the Joint Commission on Accreditation of Health Care Organizations, licensing agencies and, of course, if we have health plans, the National Committee for Quality Assurance. We believe revisions of the Health Care Financing Administration's standards in proposing changes to conditions of participation for hospitals were a positive change, as were the changes made in the PRO system.

The second factor is in performance improvement, which involves a highly disciplined examination of clinical processes. In our opinion, the improvement of clinical processes is where the real op-

portunity for economic discipline exists, finding new ways to eliminate waste, duplication and failure to manage episodes of illness.

Like a number of other speakers today, I believe much of this is built on the concept of continuous quality improvement as an approach to quality in our member institutions, combined with benchmarks and best practices that have been developed across the country and shared in networking between these institutions.

Third is our belief that coordinated care brings opportunities to measure and improve the continuum of integration of care, using such systems as CRISP, the Consortium on Research and Indicators of System Performance, which measures about 26 indicators in comparing performance and quality across 19 different health systems.

We also believe that the kind of networks that have been formed by GPIN, the group practice improvement network, where they share clinical process improvement changes, are great opportunities for us to improve quality and patient satisfaction, also that accountability means providing the information that we have available. We believe the expanded use of the HEDIS data set and other similar kinds of programs that are going to focus on not only just quality, but also the opportunity for improving performance in such areas as immunization rates are important.

Finally, in the area of coordinated care, we believe that the challenge that we have before us is the opportunity to manage the entire continuum of comprehensive health services—through coordination within the same organization and through networking of provider systems.

As that occurs, the lessons that we have learned from the Agency for Health Care Policy and Research are important tools for us to be able to begin to improve outcomes. We also believe that there is a lot to be learned in the private sector in terms of what has happened in the last few years for not only controlling costs, but improving quality.

We refer you to the CBO projection that a shift from fee-for-service health care to coordinated care in Medicare and Medicaid would reduce service utilization by approximately 8 percent. Because it offers a full range of services with bundled payment, coordinated care improves the clinical processes and can achieve cost reduction and patient satisfaction.

We believe that there are some important lessons to learn from the private sector. I think the most important one is that the Medicare Program is the largest purchaser of health care services and as such should take some of the same approaches to purchasing health care services from providers across the country that the private sector does.

I think that as they do that, they have a right to expect certain standards of quality. They have a right to expect certain standards of the sharing of information, and also should be expected to provide the right kinds of information to consumers so that consumers will have the same kinds of information that employers receive from providers. If the Medicare system takes a prudent purchaser kind of approach, I think that the beneficiaries will benefit, the providers will benefit, and it will be a more cost-effective system. Thank you very much.

[The prepared statement follows:]

Statement
of the
American Hospital Association
before the
Subcommittee on Health
of the
Committee on Ways and Means
of the United States House of Representatives
on
Medicare and Private Sector Health Care
Quality Measurement, Assurance and Improvement

March 21, 1995

Mr. Chairman, I am Gail Warden, president of the Henry Ford Health System in Detroit and chairman of the board of trustees of the American Hospital Association (AHA). I am pleased to testify today on behalf of AHA's 5,000 institutional and 50,000 individual members.

Hospitals and health systems are partners with Medicare -- the nation's largest purchaser of health care -- in serving the health care needs of the nation's elderly. AHA is grateful to share the expertise of its diverse membership, whose everyday efforts to improve the quality of the health care system illustrate the types of change Medicare should undergo in the coming years. Our membership encompasses a wide spectrum of health provider organizations: individual hospitals, health care systems, and fully integrated provider networks. These organizations were some of the first to use quality assurance techniques that are commonly discussed today, such as quality improvement, credentialing, consumer satisfaction surveys, and performance reports.

I am here today to share with you our experience. My goals are threefold. To show:

Coordinated care systems are the foundation upon which high quality care can be built.

Medicare can learn from the private sector's experiences in achieving and measuring quality.

How a high level of quality can be assured.

QUALITY THROUGH COORDINATED CARE

The foundation for building a higher quality health care system is coordinated care. When health care purchasers and providers are responsible for the full continuum of care -- from pre-natal services to long-term care -- they can track an individual's overall health status or follow a patient through an entire episode of care.

The new integrated delivery systems that providers, insurers, and employers are building can achieve a high level of quality because they can answer questions about everything from preventive services to surgical processes; they can take responsibility for the quality of the providers they select; and they can help people navigate the often-complex maze of medical decision making. For consumers, this means better, more efficient care from a system that is easier to understand -- a marked improvement over the fragmented and sometimes duplicative traditional health care delivery system.

For Medicare beneficiaries, coordinated care means greater ability to meet their needs and to deliver preventive care. More and more, coordinated care is covering all Medicare services, plus coverage for vision, dental, preventive services and even hearing aids -- benefits that most "Medigap" policies don't provide. Many coordinated care plans eliminate the 20 percent co-payment seniors must pay for doctor visits, and at the same time eliminate mountains of claim forms. These may be key reasons why a survey conducted by the consulting firm of Frederick/Schneiders for AHA found that Medicare enrollees in coordinated care plans are as satisfied with their overall care as those in traditional fee-for-service.

Most importantly, coordinated care networks can bring Medicare beneficiaries a connected health system, with everyone who provides care -- doctors, hospitals, nurses and others -- linked together and communicating with each other at every stage of treatment and service.

Moving the Medicare program toward coordinated care is an idea that makes sense and is one that many people believe will not only improve quality but also save money. According to the Congressional Budget Office (CBO), a shift from fee-for-service health care to coordinated care in the Medicare and Medicaid programs would decrease the use of medical services by an average of 8 percent.

MEDICARE CAN LEARN FROM PRIVATE SECTOR

As the largest single purchaser of health care services in this country, Medicare should take advantage of the opportunity to emulate the successes and avoid the pitfalls of the private sector's recent innovations. The provider arrangements and mechanisms for quality assurance and improvement that Medicare encourages will have a tremendous impact on how all such services are designed.

What lessons have private sector purchasers taught us? They began by trying to find the best value. Worried about costs, employers looked for health plans that could deliver services efficiently, but also answer their questions about quality. Haltingly at first and later more boldly, they urged their employees -- their "beneficiaries" -- to change plans, and sometimes to change providers. And while they found some initial employee resistance, acceptance and satisfaction grew. The search for more efficient, high-quality care has continued to lead more people into coordinated care.

Purchasers also found they have the power to affect the quality of service that is delivered. Large employers have helped create a high standard of care by requiring health maintenance organizations they contract with to be accredited by the National Committee for Quality Assurance. Medicare has also encouraged providers to achieve a high performance level through a private accreditation organization -- the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). When hospitals and other facilities are JCAHO-accredited, they are "deemed" to have met the Medicare program's conditions of participation -- standards that must be met before they can receive reimbursement from Medicare.

In addition, at the local level, business coalitions are taking a greater interest in quality by encouraging plans and providers to share information on such things as consumer satisfaction, preventive care and use of medical services.

However, as coordinated health plans took root around the country, opportunities arose for some to profit by not delivering sufficient care. Along with greater efficiency came health plans that expected people to drive long distances for care. Along came the "utilization review overseers" who sometimes went too far in suggesting that a particular treatment wasn't necessary. And along came shorter "lengths of stay" as an indicator of quality, even though it can often be argued that a longer stay means better care. In other words, some managed "care" plans did little more than manage "costs."

A health plan with an effective quality accountability process in place would avoid these pitfalls. As more beneficiaries choose coordinated care systems, the Medicare program can

also avoid these pitfalls by creating processes to assure accountability for quality. I'd like to share a framework, developed by hospitals and health systems, for doing just that.

A FRAMEWORK FOR MEASURING QUALITY PERFORMANCE

Once health care systems have the organizational structure in place to deliver services, how can they demonstrate and measure the quality of service they provide? Our members have found that there are many layers to this question, and have identified a four-part strategy to help health plans and providers measure their quality performance:

> **Demonstrate the ability to deliver quality care** -- A plan or provider must demonstrate that the necessary structures to assure quality care -- including physical plant, equipment, personnel, financing, quality assurance process, and credentialing procedures -- are in place before even opening its doors.
>
> **Improved performance** -- once the doors are open and services are being delivered, is there an ongoing process to look at how well the system is working?
>
> **Provide information for choice** -- Health networks and providers should look at how delivering care affects the individuals who receive it. This will drive people's choices about plans, providers and treatment options.
>
> **Improve the health of the community** -- Finally, the system must be able to answer questions about its effect beyond just individual service delivery -- in other words, how has it improved the health of the community?

Demonstrate the ability to deliver quality care

Currently, hospitals and health plans are subject to review by organizations like JCAHO and various state licensing agencies. Medicare conditions of participation are another example of standards that establish an organization's ability to provide quality care. These processes have traditionally focused on specific facilities. In the evolving health care climate, however, certification standards must do more than certify a single facility or organizational structure. They must also look directly at patient care, at coordination between providers, and focus more on the results of caregiving.

There cannot be a true focus on the patient when only one part of the patient's care is being addressed. As more and more episodes of care and prevention of illness are shared by different providers, it is critical to deal with the coordination among those providers -- both practitioners and facilities, and fully integrated health maintenance organizations. Technical quality of care at one site is just part of the puzzle. The pieces must be put together so they present a complete picture of what happens to the patient. The revisions the Health Care Financing Administration (HCFA) is proposing to their conditions of participation for hospitals, and changes in JCAHO standards a few years ago, went far in moving the focus onto the patient.

Both efforts attempt to move toward looking at how patients experience care by including new requirements for hospitals in such areas as patient rights and initial patient assessment. This is a good step forward, but these and other efforts to establish minimum standards should move further towards considering all aspects of a patient's care.

Improve performance

There are three ways to measure the performance of a hospital or health system: clinical expertise; the result of care; and the patient's perception of or satisfaction with that care. Every health provider or system should have an internal process to identify which practices and services need improvement, as well as which are exemplary -- "best practices," as they are called in the health field. Once this information is in hand, it should be shared with practitioners and others who are in a position to use it to improve services.

While this is primarily an internal process, hospitals and health systems recognize the need for external organizations to help them compare their performance with similar delivery systems. We see this as a potentially more positive role for the traditional Peer Review Organization (PRO).

Historically, the PROs have focused on individual clinical errors and used that information for payment denials or other punitive actions. HCFA has recognized that, in a new era of health care delivery, a more effective approach is called for. It has re-designed the PROs into the Health Care Quality Improvement Program. The new program focuses on patterns and outcomes of care, and uses this information to educate providers. Though they will always be known as PROs, there is a radical difference from the old PRO program. The new program is an effort to move the PROs from a punitive role toward a new, collaborative partnership with local providers.

We applaud this change, but we also recognize that it is a dramatic change and a challenging one for the PROs. For it to be successful, the PROs must work in partnership with providers from the identification of a problem or best practice, to the completion of the quality improvement loop: sharing relevant information with the individual practitioners it can benefit. Performance measures should not be merely be imposed on providers, but developed with them at the local level. HCFA's new approach will be successful if it complements and enhances the internal improvement process.

Many performance improvement efforts focus solely on clinical expertise. While we do not want to move totally away from technical performance, it is important to recognize the experiences and perceptions of individual patients as well. This brings us to the other areas of performance improvement -- the functional result of care, and consumer satisfaction measures. For example, looking at how soon a patient can walk after hip replacement is as important as how well the physician does the operation. So is how patients felt about how they were treated. Increasingly, consumer focus groups have revealed that people's perceptions of how they were treated is an important measure of the quality of their care.

Provide information for Choice

The third part of the quality strategy is to provide consumers with useful information to choose plans, providers and treatment options. Many of the current efforts to develop information useful for choosing plans came as a result of purchasers looking for ways to compare plans. The National Committee for Quality Assurance has been a leader in this area. It has coordinated a joint process among purchasers and health plans to develop useful measures for choosing health plans -- the Health Plan Employer Data Information Set (HEDIS). HEDIS looks at such things as immunization rates, provision of prenatal care, asthma inpatient admission rates and financial systems that help employers compare the quality of different plans.

Individual consumers, however, need different measures. If they're healthy, they want to know what the plan costs. If they've got diabetes, they want to make sure the plan has doctors experienced in treating their disease. They want to know where they have to go for treatment, and if other people are happy with the plan.

Efforts to develop useful information for individual consumers are in their infancy. As they evolve, it is important that the needs of individual consumers be considered separately from those of group purchasers.

Hospitals and health systems have extended the definition of "choice" to also emphasize the choices people make after they're in a health plan. We believe the most important consumer choices are not just the occasional decision on a health plan, but ongoing, everyday decisions about health -- decisions that many individuals feel at a loss about how to make. For example, how does an individual choose the treatment that is best when there are several options with different outcomes?

The Picker Institute, a non-profit service organization operating with support from the Commonwealth Fund, is a pioneer in this area. The institute was founded to explore ways that health providers can better meet the needs of individual patients. It developed a survey that asks patients their perceptions of how good their care was. If information like this were collected on individual providers it would serve a dual purpose: to give consumers very specific measures about how other people experience care; and to give the provider very specific information identifying areas for improvement.

Questions like "Were you satisfied, somewhat satisfied or very satisfied" are no longer adequate. The Picker Institute got specific, asking patients: whether anyone at the hospital went out of their way to make them feel better; whether they were told about the daily routine; whether they were told how much discomfort to expect before a test; whether they had a relationship of trust with any hospital staff other than the doctor in charge.

Improve the health of the community
Quality health care requires more than simply treating illness -- it also requires promoting community health. Community health improvement is a responsibility that hospitals and health systems take very seriously. It is central to AHA's vision of the future of the health care system.

To focus on the needs of individuals, health care delivery systems must focus on the environment and community in which those individuals live and work. That may mean looking at stress on the job, or nutrition at home, or violence in the neighborhood. By focusing on the needs of individuals and the community, the health care system naturally becomes more accountable to the community. For instance, it does not help the community if a provider has the best cancer treatment facility around, but prenatal nutrition and drug use are its primary problems.

That is why our vision of the future includes coordinated networks of care that are responsible for the health status of a defined population. And that is why more than 3,400 hospitals, health systems, and local organizations have expressed interest in AHA's Community Care Network Demonstration Project. The project, a collaborative effort of AHA's Hospital Research and Educational Trust, the Catholic Health Association of the U.S., and VHA Incorporated, is supported by a $6 million grant from the W.K. Kellogg Foundation. Its purpose is to support the development of community-based networks of care dedicated to improving their communities' health.

CONCLUSION

Many new thoughts and ideas were born during last year's national health care debate. Steps to assure quality were remarkably consistent in various bills, and sparked work that should continue through purchasers, like Medicare and its hospital and health plan partners, and the private sector, like large employers and business coalitions.

We all are partners in the world's best health care system. As partners, America's hospitals and health systems believe coordinated care is making our health care system even better. We look forward to our continued work with Congress and HCFA to help the nation's elderly citizens share in this improvement.

Chairman THOMAS. Thank you.
Dr. Osheroff.

STATEMENT OF WILLIAM J. OSHEROFF, M.D., VICE PRESIDENT AND MEDICAL DIRECTOR, PACIFICARE OF CALIFORNIA, ON BEHALF OF GROUP HEALTH ASSOCIATION OF AMERICA

Dr. OSHEROFF. Thank you, Mr. Chairman. I am Bill Osheroff, a family practitioner and medical director for PacifiCare of California and here to testify on behalf of GHAA and its 375 member plans.

The purposes of my remarks are first to further acquaint you with the day-to-day quality assurance activities of an HMO; two, to briefly describe some of the external oversight mechanisms that currently review us from a quality perspective; and third, to review with you some of our methodologies and results for member satisfaction surveys.

There have been profound changes in the approach to quality improvement activities in the last several years and these certainly have applied in the HMO industry as well. Whereas we used to perform quality assurance, which was largely driven by individual case review, we are now much more involved with data-driven systems approaches to quality improvement activities, population orientation and the issue of accountability, which relates to HEDIS and Delmarva that we heard about this morning.

In terms of the daily activities at PacifiCare that relate to quality assurance, we have approximately 250 to 275 medical groups and IPA's under contract. Prior to contracting with any one of those delivery systems, we perform an extensive preassessment evaluation including review of the physicians offices, medical charts, the administrative programs and systems in place.

We also do extensive physician credentialing that is designed to meet NCQA accreditation standards. We perform a number of clinical studies and other CQI activities including currently a diabetes management study. We are looking at pap smears. We are looking at participating with CMRI in some very important studies related to treatment of breast cancer and the inappropriate use of drug therapies in the elderly.

Other activities include case reviews, which we cannot get away from, and technology assessment. We have heard something about technology assessment in the development of guidelines this morning. We do that as well. We have an elaborate and formalized system for developing guidelines that we then publish to our providers.

This activity has led to a number of concerns we have had over the years. A year and a half ago we developed an ethics Committee whose membership includes a member of our Secure Horizons Program. That Committee provides us with an opportunity to have a very rich dialog regarding such issues as patient autonomy, individual determinism, equity or fairness and a variety of other very difficult ethical issues which we currently find ourselves dealing with and which all plans must.

Currently and in the last 2 years, we have been reviewed by a number of external agencies, including HCFA. We have had site visits by the California Department of Corp.s, the Department of Insurance, and HHS. We have gone through last month our second

NCQA accreditation survey and the month before that a review by the Utilization Review and Accreditation Commission. We have been visited recently by the Digital Equipment Corp., CALPERS, Southern California Edison, and the list is quite lengthy.

We applaud the efforts currently that HCFA is initiating to bring some consistency to this external review business. We find it extremely burdensome from a time resource management perspective and from a cost perspective and would look for any assistance in developing more efficient ways of performing this.

We measure member satisfaction in a number of different ways. We have what we call a member satisfaction tracking system, which in 1994 indicated that 94 percent of our senior members judged that the plan performed as well as or better than expected. Ninety-five percent indicated that they were very satisfied with the program and 99 percent indicated that they would continue with the plan.

The second way we measure satisfaction is through complaints, and we have traditionally seen a very low level of complaints, less than five per thousand members per year.

Our recent disenrollment rates for voluntary disenrollments, to be distinguished from involuntary enrollments, which are people who are deceased or move from our service area, indicates for the month of February a .68 percent disenrollment rate. We track 20 different categories, but the most common reason for leaving Secure Horizons, 56 percent of the individuals indicated leaving to join another risk plan, which makes a statement about the competitive nature of this business in the Southern California market.

The second leading reason for leaving is preferred traditional Medicare. Twenty-eight percent of the folks go back to Medicare. A very distant third is 4.5 percent who decline continued membership based on not wanting to change physicians. There is additional information in the written testimony as well.

I would welcome your questions and we at PacifiCare, as well as the other GHAA plans, look forward to continuing the dialog and providing at least a portion of the solution. Thank you.

[The prepared statement and attachment follow:]

TESTIMONY OF WILLIAM J. OSHEROFF, M.D.
GROUP HEALTH ASSOCIATION OF AMERICA

Mr. Chairman, Members of the Committee, my name is William Osheroff, M.D. I am Vice President and Medical Director with PacifiCare of California. PacifiCare is a network model HMO, which means we provide services through a network of contracted medical groups and Independent Practice Associations (IPAs). We have 650,000 commercial members and 310,000 Medicare enrollees under a product called "Secure Horizons". I am testifying on behalf of the Group Health Association of America (GHAA), the leading national association for health maintenance organizations (HMOs). GHAA's 375 member HMOs serve 80 percent of the 50 million Americans who receive health care from HMOs.

GHAA and its member plans are pleased that the Committee is focusing on quality issues in your hearing today. We come before you as health plans that provide care for about one-fifth of the nation's population -- and that offer the nation's most systematic approach to health care quality improvement.

My testimony will focus on three issues, especially as they relate to the Medicare population:

1. Describe HMO quality assurance activities, using PacifiCare as an example.

2. Briefly review current quality standards for HMOs, including the oversight by regulators (State and Federal) and private review companies.

3. Provide the results documenting HMO quality and consumer satisfaction. This will draw upon both published literature and PacifiCare specific results.

<u>HMO Quality Assurance Systems</u>

The last few years have seen a profound change in the basic approach taken by HMOs to quality assurance (QA). The early efforts in QA were directed at outlier identification, and used chart review as the principle means of case findings. The theory was that there were problems that needed to be addressed.

Influenced by the professors of CQI and TQM, HMOs are beginning to turn their attention to more data driven, systematic approaches to identifying opportunities for improving care and service. The theory in this model is that systems of care can be developed which improve the quality of care and service for <u>populations</u> of patients, not just the patients of the "outlier" physician. It is an approach that uses information, physician education and evaluation of "best practices" to improve care and service.

While the evolving internal quality systems differ among HMOs, there are four general aspects of continuous quality improvement:

- Collecting data on utilization, patient satisfaction, physician practice patterns, and performances, that allow for a clear definition and articulation of areas in need of improvement.

- Developing an intervention strategy, based on the data assessment, patient needs, scientific evidence, and clinical experience.

- Implementing the strategy -- frequently involving system changes or modification of physician practice patterns.

- Measuring outcomes and evaluating results to determine what works.

This should be viewed as a continuing, and, in a sense, "circular" process, with measurement and

assessment leading to efforts to improve care, and further measurement leading to further interventions.

In this way, the philosophy of QA is changing. The structure of the QA program at individual HMOs however has certain common elements. These include a QA/QI Committee. This typically consists of the plan medical director, participating plan physicians and various staff members. The role of the Committee is to oversee the various plan CQI activities including:

- o Provider Credentialing - physicians, etc.
- o Development of Screening and Preventive Health Guidelines - These may be guidelines for pediatric immunizations or flu shots in the senior population.
- o Plan Studies - Studies are used by the plan to test various hypothesis, see what effects specific action plans will have on the quality of care or service, or to establish baseline information that may be critical in evaluating future activities.
- o Case Reviews - Individual case review is still a necessary activity in specific circumstances. The committee provides a mechanism whereby cases may be reviewed, evaluated, categorized and followed up. This can involve a specific corrective action plan or the tracking and trending of cases over time.
- o Oversight functions - The Committee is often responsible for overseeing the QA activities of providers with whom the plan contracts. In this way, an integration of QA activities can be achieved across the whole spectrum of care being provided. These may be:

  Medical groups
  IPAs
  Mental Health providers
  Vision providers
  Pharmacy providers
  Dental providers

While HMO quality improvement programs are carried out plan-wide and are designed to benefit all members -- Medicare, Medicaid, and commercial -- HMOs can use their quality systems to focus on specific initiatives or interventions that can improve a particular aspect of health care delivery for a defined subset of members. Preventive care initiatives are one example of the wide range of quality improvement activities commonly undertaken by HMOs. Some "best practices" related to childhood immunization provide good examples:

- o 96 of 125 HMOs responding to a November, 1994 survey reported that they have implemented a program to improve childhood immunizations. The majority use provider education, patient education, and improved data collection -- and most use multiple strategies.
- o About half of the plans focus on all enrolled children under the age of 2, but others focus their efforts on specific target groups, such as families of under-immunized children or the low-income population.

When asked to cite the factor motivating their development of the immunization interventions, more than one-half the plans cited quality assurance or pediatric department staff work -- quality monitoring and assessment that stimulated the development of a program to improve childhood immunization rates. And the results of specific programs are impressive.

- o John Deere Health Care developed strategies in 1993 that increased the Measles/Mumps/Rubella immunization rate from 65% to 94% for commercial enrollees, and from 39% to 66% for the Medicaid population.

- Mercy Health Plan in Philadelphia increased the immunization rate for its Medicaid-eligible children from 46% to 57%.

Another example of quality intervention is in the area of pediatric asthma. The Harvard Community Health Plan found that this chronic condition was the most common cause of hospitalization for the children it served. Rather than focusing on treatment of acute episodes, the plan developed a comprehensive approach to managing this chronic disease, including:

- Outreach to identify high-risk patients;
- Development of an individualized care plan, including education and counseling; and
- Education on how to measure lung function so that the use of anti-inflammatory drugs can be targeted and appropriate.

The results are very promising – initial data indicate that the program reduced hospitalization for these pediatric patients by 79% percent, and emergency room visits by 86 percent.

Plans will vary in their targeted areas based on demographics, utilization or QA data, etc.

HMO Quality Systems

Stated simply, HMOs are organized systems for financing and delivering health care. They provide a vehicle for systematic quality improvement that is not as readily available in more episodic financing arrangements such as fee-for-service (FFS) plans, because HMOs combine a number of interrelated features that foster a comprehensive approach to quality. These include:

- Selection of a defined, fully credentialed network of providers who can work together on care and quality issues;
- Provision of comprehensive services across the spectrum of inpatient and outpatient settings, allowing a full range of quality interventions; and
- Clinical and fiscal accountability for the health care of a defined population -- allowing population-based data collection, analysis, intervention, and monitoring -- and fixing accountability for performance.

HMOs have made quality improvement systems a key component of their approach to care across all of the populations that they serve. Their quality approach has traditionally included a focus on the three classic dimensions of quality assurance:

- Structure, which includes ensuring appropriate professional qualifications, adequate records, proper organizational arrangements;
- Process, which encompasses the steps involved in provider/patient interactions; and
- Outcomes, which involves determining whether medical interventions achieve desirable patient results.

While HMOs continue to maintain such approaches, they have in more recent years led the way in moving toward continuous quality improvement in health care, as noted above.

PacifiCare Quality Assurance/Improvement System

We have developed a complex, multidisciplinary QI program at PacifiCare of California. The committee structure supporting these activities is depicted in the Attachment.

The basic function of our QA committee is consistent with the above comments. In addition, we have four regional peer review committees. These committees provide direct input from over 30 of our participating providers. Much of the work of these committees is to review individual medical records, develop action plans, and to review proposed guidelines, policies and procedures.

Our Technology Assessment Committee, begun in 1990, has reviewed a substantial number of medical interventions for purposes of determining where they should fit in the daily practice of medicine and for when they may be appropriate. This group draws heavily on published literature and specialists in the appropriate field of practice These are routinely sent to all our provider groups.

The Ethics Committee has been in place for 15 months. Its members include an outside, nationally recognized ethicist, a benefits manager for a large commercial employer, a Secure Horizons member, legal and regulatory representatives, a physician provider, a social worker, case management nurse, and a sales and marketing individual.

The practice of medicine is becoming more complex as we deal with new technologies and their applications. The Committee recognizes and promotes the values of the individual in health care decision making, the issues of autonomy and equity (fairness) and the difficult problems of futile treatment, patient non compliance, and responsibility.

We have trained our case management nurses in ethics and mediation skills which are proving extremely valuable in dealing with difficult medical situations. We plan to publish a report of these activities so others may learn from our experience.

We have two (2) Benefits Committees -- one for commercial products and one for government programs (Medicare and Medi-Cal). The committees ensure that our determination of benefits is consistent with regulatory requirements, coordinated with our providers and among our various departments.

Quality Standards for HMOs

Federal and state governments and private accreditation organizations working with large employers have established a wide array of quality standards, and GHAA has long supported strong quality standards for health plans.

Federal HMO Act: The federal HMO act and regulations require HMOs, as a condition of federal qualification (53 percent of HMOs are federally qualified), to have internal quality assurance programs that:

- Stress health outcomes.
- Provide review by physicians and other professionals of the processes followed in the provision of health services.
- Use systematic data collection of performance and patient results, interpret these data for practitioners, and institute needed change.
- Include written procedures for taking appropriate remedial action, in the case of inappropriate or substandard services, or when services that ought to have been furnished have not been provided.

Medicare HMO/CMP requirements: Medicare's regulations for participating HMOs and competitive medical plans (CMPs) incorporate the federal HMO act requirements for internal quality assurance programs. In addition, HMOs and CMPs participating in Medicare must maintain an agreement with a utilization and quality control peer review organization (PRO) for external review of care.

The PRO review process is moving from a focus on individual cases toward assessment of trends and patterns of care and outcomes much the same as described above. PROs review a sample of the enrollees HMO/CMP, looking at care furnished over a twelve-month period. Action plans are developed by the HMO/CMP in cooperation with the PRO to address any problems encountered, and the PRO then conducts a targeted review to determine that the problem is corrected.

GHAA has been working with HCFA in its efforts to improve the PRO review process and to focus it on performance measurement that is consistent with the evolution of quality review in the private sector. A pilot project (the "Delmarva" project) has identified and refined a set of specific clinical indicators, including certain "core" measures (time to the first visit for new enrollees, mammograms, frequency of visits/services; and flu shots) as well as some specific measures related to diabetes. This year, a selected group of HMOs and PROs will begin to work together to test these measures for an 18-month period. The goal is to develop information that will help improve PRO oversight and that will be useful to HMOs in improving the quality of care.

State requirements: The states also set quality requirements for HMOs. According to the most recent report available, 42 states have adopted some type of quality standards. The report describes "...myriad variations in the regulatory schemes by which States seek to assure their citizens' high quality health care". These include internal and external review requirements, as well as requirements related to licensure of providers enrollee satisfaction, medical records, and other matters.

The National Association of Insurance commissioners (NAIC) has adopted a model HMO Act for use by states seeking to regulate HMOs, and 28 of the state HMO acts are based on NAIC model. The model act requires HMOs to file a description of their quality assurance program, and requires that quality assurance plans include a number of specific elements.

Private accreditation: Private accrediting organizations also set standards for HMOs and assess whether the plans meet those standards. The three major groups are the National Committee for Quality Assurance, the Joint Commission on the Accreditation of Health Care Organizations (JCAHO), and Accreditation Association for Ambulatory Health Care, Inc. (AAAHC).

The NCQA is the most widely used and has gained the respect of major employers across the country. It is considered the "gold standard" for HMOs -- not an industry average or basic standard for operation. The NCQA sets specific standards and reviews plan performance in a number of areas:

- The quality assurance system -- including its effectiveness in improving quality and service;
- Credentialing process for providers;
- Utilization management;
- Member rights and responsibilities;
- Preventive health services; and
- Medical records.

PacifiCare of California was originally granted full accreditation by the NCQA in 1992. We were the first Medicare risk HMO to be so designated.

The NCQA has also worked with employers and health plans to develop a standardized set of comparative information for health plans to report. The Health Plan Employer Data and Information Set (HEDIS) is comprised of 60 performance measures designed to give employers and consumers objective information on health plan performance. HEDIS is the first step in the development of a standardized set of performance measures for HMOs.

A comparable effort is underway to develop "report cards" on HMOs that will be useful to consumers in making informed choices. As such efforts become more sophisticated, it will beimportant for consumers to have data on the fee-for-service sector that permits an additional dimension of comparison.

The Results

Discussion of different quality models and systems is irrelevant in the absence of results. The success of HMOs in improving quality of care has been documented again and again, as studies show care provided in HMOs to be as good or better than care provided in fee-for-service (FFS) plans.

A comprehensive review of the literature published from 1980-1994 appeared in the May 18, 1994 Journal of the American Medical Association. It analyzed 16 studies comparing quality of care in HMOs with care provided to similar populations in other settings. The study concluded that HMO quality is better than or equal to the FFS results on 14 of 17 measures. People cared for in HMOs consistently receive more preventive care -- such as breast, pelvic, rectal and general physical examinations -- as well as more health promotion counseling.

Some specific examples of studies on quality of care in HMOs are outlined below.

- Elderly HMO members with cancer are more likely to be diagnosed at an early stage than those in the FFS system, according to a HCFA study that compared Medicare records for 12 different types of cancer. Breast, cervical and colon cancers, along with melanomas, were diagnosed significantly earlier in HMOs than FFS. The largest difference was for cervical cancers: almost 60 percent of HMO members were diagnosed at the earliest stage, compared with 39 percent of FFS patients (American Journal of Public Health, October 1994).

- HMO appendicitis patients were 20 percent less likely to suffer a ruptured appendix than appendicitis patients in a FFS setting, according to a study of hospital records in California (New England Journal of Medicine, August 18, 1994.

- Women in HMOs were more likely to obtain mammograms, Pap smears and clinical breast exams than women in FFS settings. For example, 62 percent of women HMO members age 50-64 had a mammogram within the past year, compared to 50 percent of women in FFS (CDC/NCHS Advance Data No. 254, August 3, 1994).

Another recent review reported by Joan Meisel, PhD, MBA at Stanford University entitled "Quality of Care in HMOs: A Review of the Literature" reaches the same conclusions -- that HMOs do not compromise the quality of care and are rated superior to fee-for-service in many important ways.

Finally, HMO members -- elderly and non-elderly -- are more satisfied overall with their health plan than FFS enrollees. For example, a survey of 19,000 elderly Americans by the National Research Corporation found those enrolled in HMOs had higher satisfaction levels than traditional FFS Medicare enrollees for every level of health status.

At PacifiCare we measure member satisfaction in several ways. First is the Member Satisfaction Tracking System (MSTS). This program involves a telephone survey of a statistically valid sampling of members for each of our contracted medical groups/IPAs. These results show that 95% of surveyed members are satisfied with the plan and their medical group. Ninety four (94) percent believe the plan performed as good or better than expected. Ninety nine (99) percent report they are likely to continue coverage.

The second measure of satisfaction (or dissatisfaction) is the number of complaints. This has

consistently been low, and currently is <5 complaints per thousand members per year (4.64 for CY 1994.).

The third indication of member satisfaction is the enthusiasm of the seniors for this product in new markets. Secure Horizons is a tremendous value for the senior. Not only do they receive Medicare benefits, but Secure Horizons provides a pharmacy benefit and dental benefit. Further, we provide services that include aerobics classes and counselling on a variety of health related topics.

Kern County (Bakersfield) is an example of a new market and how quickly seniors will embrace a managed care approach. In three years, we have enrolled 14,376 new members in this market. There are 61,436 seniors in Kern County. Thus we have enrolled 23% of the county's senior population in a short period of time.

Perhaps a more important indication of satisfaction than enrollment rates is disenrollment rates. People can join a plan, but little is gained if they disenroll in a short period of time due to dissatisfaction.

The following table summarized the data for February, 1995:

Voluntary disenrollments	2,078 (63.3%)
Involuntary disenrollments	1,206 (36.7%)
Total	3,284 (100%)

"Involuntary disenrollments" represents deaths or individuals who move from our service area. Average membership during this month was 301,776. The voluntary disenrollments represent 0.68% of the membership. This is extremely telling.

The ten most frequent reasons for voluntary disenrollment are as follows:

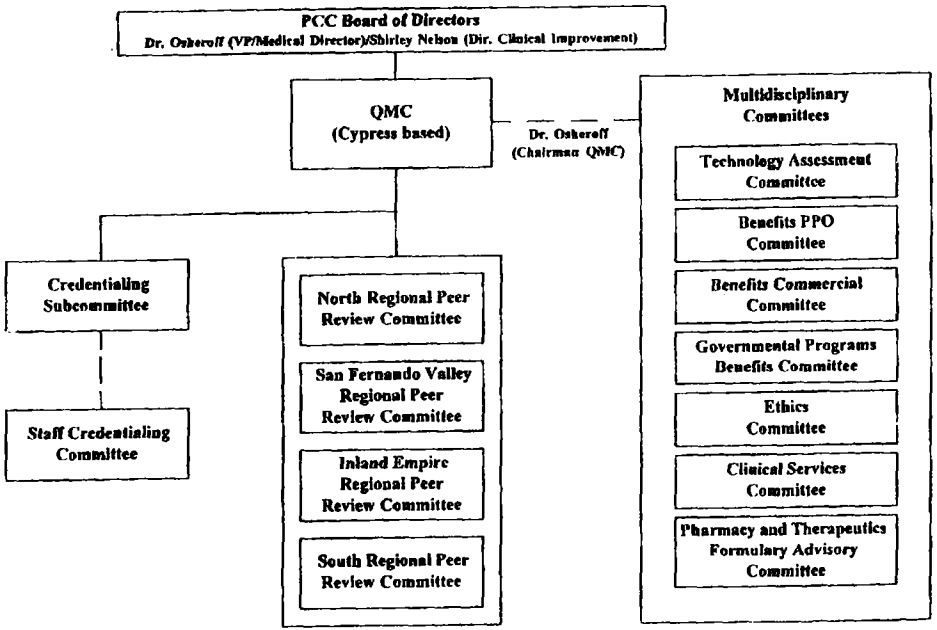
	No. of Members	%
1. Joined another risk plan	1,182	56.0
2. Prefer traditional medicine	590	28.4
3. Doesn't want to change physician	94	4.5
4. Other	65	3.1
5. Lock-in features too restrictive	23	1.1
6. Benefits are insufficient	16	0.8
7. No/little choice of specialist	8	0.4
8. No/little choice of PCP	7	0.3
9. Failure to refer/authorize	6	0.3
10. Doctor couldn't improve condition	3	0.1

As you can see, the voluntary disenrollment rate is very low. The major causes of disenrollment relate to the competitive environment in which we operate, and the difficulty in transition from FFS medicare for some members. Only 23 members (out of 300,000+) found the HMO lock-in features too restrictive.

We believe these results indicate a very high level of satisfaction with our plan.

Mr. Chairman, HMOs provide high quality care to 50 million members today – and are working to continue to improve the care that we provide in the future. The GHAA would be pleased to work with the committee as you examine the issue of quality in health care. I wish to extend to you and your Committee an invitation to visit our plan and gain first hand knowledge of our operations. I would be happy to answer any questions that you may have.

COMMITTEE RELATIONSHIPS



Chairman THOMAS. Thank you very much, Doctor.
Miss Braun?

STATEMENT OF BEATRICE BRAUN, BOARD MEMBER, AMERICAN ASSOCIATION OF RETIRED PERSONS

Ms. BRAUN. Mr. Chairman, my name is Beatrice Braun from Spring Hill, Florida. I am a member of the board of directors of the American Association of Retired Persons. AARP appreciates the opportunity to appear before the Subcommittee today to discuss quality oversight in the Medicare Program.

As you can imagine, when we hear from our members about quality issues, they do not usually express their views in policy talk. For this reason we have attached to our testimony a checklist of key aspects of quality from a consumer perspective. We think that these 10 items, such as competence, compassion or bedside manner and communication help to capture what is needed to ensure continuing consumer confidence in the quality of care.

This hearing occurs on the eve of the 30th anniversary of Medicare. During the past three decades we have witnessed the evolution of a system that has provided security and peace of mind for millions of our citizens based upon the delivery of high quality medically necessary services.

As we debate Medicare's future, we must not forget our responsibility to preserve its strengths, including its current Quality Assurance Program, and to change it only in ways that will continue to improve the health status of beneficiaries. AARP believes that a strong system of quality oversight must continue to be a key component of the Medicare Program.

Because Medicare is being confronted with both tighter budgets and growing needs, beneficiaries must have confidence that the quality of the services they receive will not suffer in the face of these financial pressures. Maintaining a quality health care system begins with protecting Medicare's benefits package and includes preserving the affordability that has always been key to Medicare, along with the freedom to choose providers and health plans. The basic assurance of a system of comprehensive affordable care is the foundation for all of our quality improvement recommendations.

In our written testimony, we have detailed a number of specific initiatives that will help preserve and enhance quality within the Medicare system. AARP has been pleased to work with the public and private sectors in these areas.

Specifically, we note the following: First, we applaud efforts by HCFA and NCQA and the Joint Commission to develop comparable measures of performance in health plans and to release data to the public. To be successful, these initiatives will require providers to submit standardized data, which is not currently being done by some managed health care plans. HHS could further this goal by requiring standardized data collection for all public programs.

Second, we are encouraged by efforts of AHCPR and others to conduct outcomes research and develop clinical practice guidelines. This enormous task requires public-private collaboration. Guidelines have not yet been developed for many important conditions, particularly chronic conditions of older persons.

Third, we are encouraged by efforts to develop useful consumer information and to communicate with Medicare beneficiaries. Such information is an important component, although it will never be sufficient alone to assure quality.

Finally, we support efforts to strengthen current quality safeguards. Medicare appeals and oversight by peer review organizations are vital to consumers and we urge HCFA to continue to improve their functioning.

As the Congress considers ways to restructure the Medicare Program, preserving and enhancing quality must remain a priority. Strengthened safeguards will be needed in new delivery systems, because while they may reverse incentives toward overservice, they pose a potentially greater risk of underservice.

Thank you for this opportunity to present AARP's views on some of the major policy issues concerning Medicare's Quality Assurance Program. We would be pleased to work with Members of the Subcommittee on ways to improve the quality of care for all Medicare beneficiaries. Thank you.

[The prepared statement and attachment follow:]

TESTIMONY OF BEATRICE BRAUN
AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. Chairman and members of the Subcommittee. I am Beatrice Braun from Spring Hill, Florida. I am a member of the AARP Board of Directors. I appreciate the opportunity to appear before the Subcommittee today to discuss quality oversight in the Medicare program.

This hearing occurs on the eve of the 30th anniversary of the Medicare program. During the past three decades, we have witnessed the evolution of a system that has provided security and peace of mind for millions of our citizens based upon the delivery of high quality, medically necessary health services. As we debate Medicare's future, we must not forget our responsibility to preserve its strengths, including its current quality assurance program, and to change it only in ways that will continue to improve the health status of beneficiaries.

AARP believes that a strong system of quality oversight must continue to be a cornerstone of the Medicare program. There are few aspects of the program that matter more to beneficiaries than preserving and enhancing the quality of care. Because Medicare is confronted, today and for the forseeable future, with both tighter budgets and growing needs, beneficiaries must have confidence that the quality of the services they receive will not suffer in the face of these financial pressures.

Today, we are discussing ways to improve the quality of care in both fee-for-service and managed care settings. Regardless of how beneficiaries receive their care, we must be vigilant so that all – including those who are sickest and most at risk -- receive appropriate, affordable, high quality care. While a system involving greater enrollment in managed care offers the potential to improve the quality of care, this potential will not be realized unless there are rigorous protections against the risks of underservice and poor quality care. It is fair to say that beneficiaries' perception of the quality of care in these new delivery systems will be driven not by stories of unnecessary care avoided but by "horror stories" of needed care deferred or denied.

What do consumers mean by "quality" of health care? Most importantly, it is the assurance that they will be able to have their health care needs met when they need care and by providers whom they trust. This implies that the Medicare benefits package that older Americans depend upon today should not shrink, and in fact, should expand to include coverage for significant gaps, such as prescription drugs. Affordability is also central to beneficiaries' view of a quality health system -- beneficiaries' out-of-pocket costs cannot continue to grow such that they can no longer afford access to care when they need it. Choice of providers and of delivery systems is another valued component of the current Medicare system; indeed, Medicare beneficiaries' health coverage options need to be expanded, as has occurred for the under-65 population in the private sector. But this should not be done at the cost of reducing Medicare's benefit package, increasing beneficiaries' out-of-pocket costs, or jeopardizing Medicare's broad insurance pool, which permits risks to be spread and makes affordable health care possible.

Quality of care goals

AARP believes our quality of care goals should be:

- To assure individuals that they will be able to have their health care needs met, as well as to improve the overall health of various populations.

- To preserve choices for consumers that result in the delivery of comprehensive, affordable care, as well as to to provide for the skilled management of care.

- To prevent the withholding of necessary and appropriate care, as well as to avoid delivery of unnecessary or inappropriate care.

- To improve systems of care through the application of continuous quality improvement approaches, as well as to ensure the detection and cessation of practices threatening individual patient well-being.

- To enhance consumer decision-making capability through disclosure of treatment options, risk-benefit considerations, and outcomes, as well as to strengthen mutual respect and trust between practitioners and patients.

Improved Performance Measurement Across All Care Settings

"If you can't measure it, you can't monitor or improve it." In the private sector, organizations such as the National Committee for Quality Assurance (NCQA) and the Joint Commission of Health Care Organizations (JCAHO) are playing leadership roles in the difficult task of developing comparable measures of performance in health plans and health care organizations, and in releasing these data to the public. In the public sector, the Health Care Financing Administration's (HCFA's) efforts to develop indicators of quality of care in all settings, including home health and skilled nursing facilities, as well as in physician offices and hospitals, are vitally important.
We believe that the new performance measurement systems being developed in both the private and public sectors should include measures of access to and timeliness of care, appropriateness of the setting and treatment, and premature hospital discharge. As soon as possible, these measures should encompass the entire range of care delivered and a wide range of clinical conditions, especially chronic physical and mental disorders. (For example, knowing that a plan performs well for someone with diabetes doesn't necessarily mean that it does so for patients with other conditions.)

We are pleased that private accrediting bodies and the Department of Health and Human Services (HHS) are making considerable progress in developing and pilot-testing quality of care indicators in both managed care and fee-for-service settings. However, we urge them to move forward even more rapidly. If the focus is on only a small number of conditions and too few measures, quality of care could be imperiled if providers "study for the test" (e.g., focus their resources on the few conditions being studied to the detriment of patient care in other areas).

Standardized Data Collection

The key to a comprehensive performance monitoring program -- and to providing useful consumer information -- is a uniform data collection tool. This tool should have uniform definitions that permit comparisons of health encounters, regardless of the source of payment or setting, at the same time that it protects patient privacy and confidentiality. Such a tool would help consumers make "apples-to-apples" comparisons and would reduce the cost and administrative burdens on providers and plans.

Currently, some managed care plans cannot report basic utilization data, such as the number of patients seen with a specific diagnosis and what treatments they received. Hence, as a first step, HCFA should consider requiring Medicare and Medicaid managed care organizations to collect the data on the forms used in the fee-for-service setting for documenting and reimbursing ambulatory and hospital care. (These forms, the HCFA 1500 and the UB'9 respectively, include data on patient age and gender, place of service, diagnoses, and procedure codes.) Since the majority of the nation's providers are already familiar with these instruments, they may be the most practical foundation upon which to build. Additional data elements essential to providing a comprehensive picture of care -- such as medications currently being used and functional status -- could be added over time.

Clinical Practice Guidelines and Outcomes Research

The growing movement to expand medical effectiveness research and outcomes research -- in order to identify when services are beneficial and when they are not --

holds great promise for improving quality and reducing the costs of medical care. The major "products" of this movement are clinical practice guidelines to guide practitioner and patient decisions about appropriate health care for specific clinical conditions.

AARP has been supportive of the efforts of the Agency for Health Care Policy and Research (AHCPR) and other agencies within HHS to conduct outcomes research and to develop practice guidelines, which still don't exist for many conditions. Federal support for these efforts is critical, as is the need for private and public sector collaboration in developing, disseminating, and evaluating the use of guidelines in practice.

AARP is particularly interested in seeing expanded outcomes research on and the development of more clinical practice guidelines for chronic conditions. From the perspective of all beneficiaries, but especially those with chronic conditions, outcomes of care should include those that relate to the quality of life, such as physical functioning, social and role functioning, and emotional well-being. Because chronic illnesses cannot be "cured", the emphasis should be on helping individuals cope with changes as the disease progresses, on preventing further disability and optimizing functioning and well-being. For the chronically ill, it also is particularly important to track the continuity of care across multiple settings, including home health care and other long-term care settings, and to assess the interpersonal aspects of care (such as patient-physician communication).

Communication with Beneficiaries

Another crucial need is improved outreach to and communication with beneficiaries, and we are encouraged to see HCFA's new emphasis on these areas. This communication should be a two-way street, in which information is both gathered from beneficiaries as well as provided to them to help inform their health care decisions. Beneficiaries' satisfaction with care reflects both how they have been treated and their health outcomes. In addition to being asked about their satisfaction with care, beneficiaries should also be asked about their health status and health care experiences. For example, research indicates patients accurately report information about their medical care, such as whether they received their test results and were told whether further care was needed. These patient-based data, which can be used to construct measures of clinical performance, are a promising, potentially cost-effective, but underutilized method of data collection. Hence, AARP believes that constraints to the use of both patient and consumer satisfaction surveys should be removed as soon as possible. Finally, as HCFA is proposing to do in its new Consumer Information Strategy, information should be provided to beneficiaries in such areas as prevention, treatment options, and to also help them choose among health coverage options.

Consumer Information

There currently are numerous efforts underway in the private and public sectors to provide consumers with information to help inform selection of health care plans and, to a lesser extent, providers. We strongly support efforts to provide consumers with "report cards" on plan and provider performance that present accurate, comparable information in formats that are "consumer-friendly." Accomplishing this goal, however, will take a long time and significant investment. We applaud efforts, such as the recent NCQA pilot report card project for managed care plans, that move us closer to this end.

We also believe that the public sector is in a unique position to foster the development of useful consumer information. Although much maligned, HCFA's hospital mortality reports broke new ground in the public release of outcomes information, and paved the way for the more useful provider-specific data reports that are currently published in several states. The AHCPR has also embarked on several projects that should result in better public information, notably the development of a model consumer survey designed to help consumers make choices among alternative health insurance options.

Consumer information alone, however, is not sufficient to assure quality accountability. We would never want to see the day when Medicare beneficiaries, including those who are very sick and very frail, feel that "caveat aeger" (let the patient beware) is their chief protection.

Due Process and External Quality Oversight

Many of the strategies for improving quality discussed above -- including more comprehensive performance measurement systems and consumer "report cards" - presuppose the future development of better data systems and research methodologies. The "state of the art" is such that there must also be ongoing attention to the strengthening of current quality safeguards, i.e., due process and external quality oversight protections.

Due Process:

The Medicare program must continue to protect beneficiaries from poor care. Currently, such protections include a complaint system utilizing Peer Review Organizations (PROs), informing patients of their appeal rights upon admission to a hospital, and a uniform, national appeals mechanism for medical care denials. As Medicare evolves and beneficiaries enter into different kinds of relationships with providers, these complaint, due process, and appeal mechanisms must be strengthened. In addition, ways must be sought to improve the coordination of protection efforts of state and federal investigatory and disciplinary bodies; PROs should continue to have the authority to make appropropriate referrals for disciplinary action when needed.

External Quality Oversight:

External peer review has been a feature of the Medicare program since the early 1970s. Since the mid-80s, AARP has been actively monitoring the development of the PRO program. While imperfect, the program functions as an important part of the patient protection and quality assurance structure. More specifically, through its federal standards, it provides the structure needed to assure the delivery of high quality care regardless of where one lives, and to hold individual and institutional providers and plans publicly accountable for improving performance.

Recently, the PRO program has undergone a fundamental change from a focus on individual errors to identifying opportunities to improve the mainstream of care. AARP is hopeful that the introduction of a continuous quality improvement model, which seeks to educate and facilitate rather than to punish, will succeed in fostering the delivery of higher quality care.

Among those aspects of the PRO program that are most critical to consumers are:

- **Monitoring access to and quality of care**. Even the best informed consumers will often not be able to tell whether or not they are receiving care based on the best medical practice, especially when they are very ill. Hence there is a need for expert, objective professional oversight to foster care of high technical quality that is based on clinical practice guidelines, when they exist.

- **Consumer representation**. Consumers are represented on the boards of PROs in all 50 states; this consumer representation must not only be maintained but expanded.

- **Community-based initiatives**. An important PRO function is to help practitioners and plans reach quality levels achieved by the best performers. In order to improve performance, PROs are now sparking community-based initiatives that bring together all parties (practitioners, plans, and, occasionally, consumers) to respond

to locally-identified needs. We see these initiatives as promising, and think they will be even more effective if they actively involve consumers.

- **Ongoing quality oversight**. A critical element of PROs' monitoring activities is that they occur on a continuous basis, i.e., ongoing problem identification and problem-solving take place through community-wide pattern analysis.

AARP believes that the Medicare progam must continue to hold plans and providers publicly accountable through ongoing, skilled professional oversight, utilizing a state-based infrastucture that permits an essential presence at the community level.

This by no means precludes the contribution of national accreditation entities, whose efforts in fostering standard setting, continuous quality improvement, and comparative analysis of performance are accelerating. Medicare should continue to work collaboratively with the private sector in pioneering and adopting cost-effective ways to improve quality.

Conclusion

As the Congress considers ways to restructure the Medicare program, preserving and enhancing quality must remain a priority. Strengthened quality safeguards will be needed in new delivery systems because they reverse the current incentives toward overservice and pose the risk of underservice. Improved performance measurement, communication with beneficiaries, and consumer information will be necessary but not sufficient elements of this system; of equally vital significance will be public accountability, accessible grievance, appeals and due process mechanisms, and skilled external professional oversight.

Thank you for this opportunity to present AARP's views on some of the major policy issues concerning Medicare's quality assurance program. Of course, when we hear from our members about quality issues, they don't usually express their views in "policy talk." Hence, we have appended to our testimony a checklist (Appendix A) of key aspects of quality from a consumer perspective. We think that these ten items help to capture what is needed to ensure continuing consumer confidence in the quality of care.

We would be pleased to work with members of the subcommittee on ways to improve the quality of care for all Medicare beneficiaries.

Appendix A

Quality from a Consumer Perspective: The Ten "Cs"

Competence	of providers and health care practitioners
Communication	such as explanation of medical procedures and tests; paying attention to what the patient says
Compassion/Caring	courtesy, personal interest, respect, time
Continuity of care	such as ability to see one's usual provider
Continuum of care	full range of acute and long-term care services
Choice	of delivery systems as well as doctors; more generally, consumer empowerment
Complaint Resolution	timely, accountable procedures for grievances and appeals
Convenience	of location, access to primary & specialist care when you need it; getting medical advice by phone
Coordination	no delays in your medical care; communication among doctors or staff who provide care
Community oversight	state or locally-based organizations monitor quality of and access to care, based on federal standards

Chairman THOMAS. Thank you very much, Mrs. Braun.

Dr. Nelson, your organization probably as much as any has had an ongoing discussion about how you relate to health care changes. We have been focusing on measuring tools, quality versus cost. Do you folks believe that there is a way to create a measuring device that would cut across all of the various delivery mechanisms that we now have; that is, is quality quality, whether it is the old fee-for-service or an HMO or a physician hospital organization or a PPO, or do you think we might need to use slightly different standards for different structures to measure quality?

Dr. NELSON. That is a very good question, Mr. Chairman. The fact is that quality is quality and it can be measured. A couple of premises.

Premise one is we believe that quality controls costs, not the other way around, and that there are three aspects of quality which can be measured and are currently being measured. One is the medical outcome, did the person have the right diagnosis, right tests. Did the patients live or die?

Second and significantly, is patient satisfaction being measured carefully. We talked about the hotel functions of a hospital. Patients want to know if their care giver is actually giving information and how they perceive the quality of care. Third is was it done efficiently, and that can be measured as well. Those quality indicators would work irrespective of the system in which the care was provided. The quality must be provided in any of those systems, and that is our concern.

Chairman THOMAS. Another concern that I know doctors have had is the whole question of practice guidelines. It is the old business such as in our business, if you let me pick the ones, I am more than willing to follow them, but when someone else picks them then I have some concern. You know we will be developing a number of competing practice guidelines.

Is AMA looking at or do you have any mechanism or structure to help resolve a choice question between competing practice guidelines?

Dr. NELSON. Yes, sir. We have put together the practice parameters partnership. This has in it several hundred practice guidelines, and so forth. When there are competing practice guidelines, these groups are brought together to agree to agree. That has occurred. There were three, for example, on gestational diabetes or diabetes in pregnancy, and there certainly needs to be a way to bring those together. Yes, that is being done.

The second answer to your question, if you would come West, and we invite you to Utah you would see that this is being done in a partnership between the private and the public sector where health system reform, which is ongoing in our State. We have a large consortium of people involved in quality which will be from our PRO, private carriers, State health department, and others to get together to do in an ongoing basis so we can agree to agree.

We believe that this can be done. We believe that it must be done. As a matter of fact, our health reform in Utah is being based on the premise that costs saved, which we must see up front from this process, will be used to give care to those who currently do not have it, and it is working.

Chairman THOMAS. Do you have examples? Earlier with the HCFA panel and Dr. Lee, we talked about some early success stories or breakthroughs in terms of utilizing guidelines or quality control.

Do you have any examples or is it too early to talk about specific changes that were dramatic or helpful?

Dr. NELSON. There are three. The most dramatic is in a disease called adult respiratory distress syndrome or ARDS. It is a disease that is a almost uniformly fatal, with death rates of around 90 percent. Before the implementation of practice guidelines that were generated by the practicing physicians, our death rate, too, was around 90 percent.

We now have a 44 percent success rate, meaning people who live, and the best part is, by following the guidelines developed by our physicians, we are saving in the neighborhood of $40,000 per case.

The second simple example is in the issue of wound infections after surgery. National standards suggest that 2 to 4 percent of the time that ought to occur. In our hospital it was 1.8 percent before initiating the guideline, 0.4 percent afterward.

We saved three quarters of a million dollars in 1 year in our hospital because we didn't have the infections to treat. You wanted a dramatic one; it used to take 21 days to get your little card that said you could be a member. Now it takes 4 days. By quality methodology, we found four desks on which the card sat and no one knew the reason why. We eliminated those. So, we have three simple breakthroughs, the point being that, yes, it can be done. It is being done and it does not just have to do with clinical medicine. It has to do with all aspects of health care.

Chairman THOMAS. I think that probably more than anything else, telling some success stories to encourage people to take a serious look at it and move forward probably does a better job than anything else. I have some questions for the other members of the panel, but I know the gentleman from Nebraska wants to inquire.

Mr. CHRISTENSEN. Thank you, Mr. Chairman. Mr. Warden, I have heard testimony earlier today about mandating health care institutions and doctors in terms of getting sound testing requirements and monitoring some of the things that they are doing from a government standpoint. Being a free market, conservative, entrepreneurial capitalist, I believe that we need to keep government out of that as much as possible.

I know there is a role for Government. In your opinion, what would be the best avenue to follow? Is it a role that Ms. O'Kane talked about in using the National Committee for Quality Assurance? Is your particular hospital following some of the things that they do in NCQA or do you think that it would be better to follow a more regulatory approach that maybe we heard in testimony earlier today by some of the earlier witnesses?

Mr. WARDEN. I think, Mr. Christensen, that the best approach is one in which there is kind of a partnership between the private and public sector in which the accreditation or certification system resides in the private sector, but there is an ongoing dialog with the public sector about what their expectations are.

We found that both with the Joint Commission on Accreditation of Health Care Organizations and with the National Committee for

Quality Assurance that the kind of approach where we voluntarily participated with them and had the opportunity to do so in developing standards, and then agreed to adhere to those standards as part of their accreditation or certification process, is the most workable one, and I think that it is probably also the more cost effective compared to a more regulatory approach.

Mr. CHRISTENSEN. If that is the case, then what role do you think the Federal Government has and to what extent might we be required to fund research to support evaluations in government policy changes and making this information available to the public?

How much and to what degree should government fund these various studies? If you look at our last panel, less than 5 percent of the funds in each one of the respective groups came from the Federal Government, whereas, other testimony we heard placed it at a more significant amount.

Mr. WARDEN. I think that government has a role in helping to develop tools and approaches. In most cases in the private sector we do not have, unless we get a grant from a foundation, we do not have the sources of dollars to be able to do that because it is not something you would consider the patient should pay for.

However, in our own organization we found that just as the doctor on my right from the AMA has done, we found that once we have some information and understand the kinds of approaches that can be taken, much of it can be done at the local level. We have done it in about 10 different conditions, and each one of them, I will not go into the examples, but with each one we have had the same kind of savings and the same kind of increased patient satisfaction.

The important thing is that there are mechanisms, as AMA has stated, to enable us to share this information between organizations and to network so that we continually learn. Outcomes research and practice guidelines are not something you develop, and then they just exist forever. Medical information is changing all the time and it has to continually be improved.

I think basically the successful strategy requires a public-private partnership, and a lot can be done in the private sector.

Mr. CHRISTENSEN. I agree. I want to make sure that we try to keep as much as possible in the private sector. I have just seen the efficiency of the Federal bureaucracy and it is not something that I want to trust to further studies and testing, giving the government the opportunity to go unfettered with their discretion. I think it is something we have to be very careful of.

I agree with what you say, but am very skeptical of the Federal Government. I appreciate your testimony.

Chairman THOMAS. I thank the gentleman. I am concerned as well, Dr. Osheroff—one of my big worries is that as we move into the regulatory area here, which government drives itself toward, we do not get into the situation as we have with some other activities in which you have a competing State and Federal structure, and that instead of having a harmonious working relationship you are required to operate under two different standards with the double paper work. Our goal is to not create another torture weapon out of quality standards, but to provide a clear yardstick by which consumers can make that decision.

Ms. Braun I noticed in your testimony that you said, Medicare beneficiaries health coverage options need to be expanded, as has occurred for the under 65 population in the private sector.

One of our goals in this Congress is to make sure that the seniors have a wide range of choice, and choice is the key that they get to choose. In these new managed-care programs, as is done in the private sector and with the government health programs, you oftentimes have a season or a period of choice in which you choose a plan.

We discussed earlier about the difficulty of a 1-month, for example, election structure. Does AARP, or do you have any feeling about creating an annual enrollment period like we seem to have more and more now as a common practice in employment situations?

Dr. BRAUN. I think AARP would be concerned about making that change at this time because I think the ability to disenroll does act as a help in the quality area. The other thing, since we are hoping that more and more Medicare people will move into managed care, If think the fact that they know that they can disenroll if it is not working out for them, I think will be a drawing card in helping them to try it out because older people, as you know, tend to feel insecure in changes. I think it is a help, also from that point of view.

Chairman THOMAS. Well, as the rest of the world continues the change in the health care delivery and the seniors talk to their children about their managed care programs, we are creating an atmosphere where it is a little more receptive. I was impressed with the 28 percent figure which I consider fairly low. A major decision for a number of folk is in a different world, although that different world promises through a total integrated preventive care structure some benefits that are not currently available.

I normally do not do this with witnesses but, Ms. Braun, since you are here representing AARP, I would like to ask you a personal question.

Dr. BRAUN. All right.

Chairman THOMAS. I have a partial answer to it but I do not know the reason. I was curious, coming from Florida, I know in California and in the northwest, and in Florida there are a number of managed care programs that are available. I understand you have not chosen to go that route.

Dr. BRAUN. No, I am not. This morning I am testifying certainly as a consumer, a member of the AARP board of directors. I am also a physician and I think that I sort of act as the primary care physician in my own care and my husband's care.

Chairman THOMAS. See, I did not have that information available to me.

Dr. BRAUN. I am sorry.

Chairman THOMAS. That is a help in understanding the choices that you made.

Dr. BRAUN. There is another reason though, Mr. Chairman, I think this will apply many other places, also. We in our county just got our first managed care about 3 months ago for Medicare. I am sure there are lots of areas in the country where—in fact I was

talking to some other AARP people from other areas like Idaho and so forth where there really is not very much managed care at all.

Chairman THOMAS. In the heartland of the country, that is one of the things we are going to grow.

Obviously, then, you are qualified by far more than the age criteria to testify with AARP. I would ask you from your professional viewpoint, are things going in the right direction? When you talk with other seniors, when you have your AARP meetings, are people talking about, "experimenting with the idea of managed care"? Are people giving us good stories about the successes that they have had more often than not? What is your personal observation?

Dr. BRAUN. I think many people are anxious. The fact that they do not need supplemental insurance, that they get more coverage and so forth is definitely a drawing card.

I think more and more they are trying out managed care. As you know, in Florida, we have had concerns about managed care that it has not done very well, but I do think that people are moving. My understanding is that actually 1.5 percent of Medicare beneficiaries are moving every month into managed care. I really appreciate the fact, and AARP does, that this is a voluntary situation because it will gradually grow.

Chairman THOMAS. It will remain voluntary, but obviously quality standards such as we are trying to begin to achieve here will be very helpful.

Dr. BRAUN. Yes.

Chairman THOMAS. Final question. You heard the earlier panels talk about the desire for a relatively extensive checklist and I believe your testimony indicated to a certain extent as well.

I am concerned about the desire to heap far more information on folks to make a decision than perhaps they want and that to a certain extent tends to be confusing rather than helpful.

From your perspective, again, in terms of knowing people who are faced with this decision, would it be helpful to have a good housekeeping seal of approval for some structure in which they have trust, such as the Medicare structure approved programs, without necessarily having to go into the detail to allow people to have sufficient information to make a choice from a long checklist?

Dr. BRAUN. I think probably it would be helpful—

Chairman THOMAS. The best answer is both, I know.

Dr. BRAUN. Yes. But, I think it would be helpful to have, as it were, a seal of approval, but I think there are many Medicare beneficiaries who would appreciate having the kind of information that employers are looking for when they are looking at health plans and deciding what they are going to give their employees and so forth. I think there are a lot of people that would utilize that kind of information. It would be helpful.

Chairman THOMAS. One last question, in trying to create a program where people choose an alternate route, and there may be savings, do you think it would be useful if the program was set up where people could share in the savings of their chosen route, and perhaps that savings could be passed on to the consumer if a choice is made available? Would that be an added incentive along with the enhanced benefits?

Dr. BRAUN. I think the enhanced benefits is more of a drawing card than anything else at the present time because there is a great deal that is not covered by Medicare and some people that fall into that lower group above poverty, but still not really wealthy cannot afford Medigap insurance. So, it is really valuable for them to move into something else.

Chairman THOMAS. Prescription drugs is one of the items very often available and that is a nice addition.

Dr. BRAUN. Very true. Community-based care, that kind of thing, as those experiments go on, pilot projects go on and so forth, I think they will be great drawing cards where long-term care will also be covered.

Chairman THOMAS. The gentlewoman from Connecticut, did you have a question?

Mrs. JOHNSON. In listening to the Chairman's questions to you, Ms. Braun, and the panel, one of the things I am wrestling with in my own mind is, is it necessary to have different mechanisms to oversee the quality of managed care systems if seniors join those systems? Are they adequately protected by the same oversight mechanisms that are in place for everybody else in that managed care system?

See what I mean? In other words, in your testimony, Ms. Braun, you look to preservation of the existing mechanisms to protect seniors from inadequate care and so on and so forth. It is my observation that through the casework in my office, those mechanisms are working very well. I get many fewer complaints as an elected representative from people in managed care systems than I do from seniors in Medicare.

I do not see any clear case as to why the Federal Government should layer on new oversight mechanisms onto managed care plans that are already out there serving people of every other age just because we allow seniors to join them. See what I mean?

Dr. BRAUN. I do see what you mean, but I think there are concerns about something that would replace the PROs now if they were gone. There are certainly things that seniors do need to be protected—for instance, chronic illnesses and treatment of chronic illnesses and so forth, which are really not being given much attention so far. I think there really are some areas.

It may be that at some point the accreditation or some kind of ongoing monitoring being done generally will be applicable, also, but I do not think we are at that point yet. I think we need to continue with having PROs at least for the present.

Mrs. JOHNSON. Consumer education, that kind of information is necessary, and the education that goes along with being able to understand the information, but I am concerned about a Federal initiative to put a specific new requirement on managed care plans unless there is a clear case to be made. I appreciate your talking about chronic disease.

Do any of you have a comment on that whole issue? As we give seniors options, do we have to layer on new levels of regulation?

Mr. Warden.

Mr. WARDEN. I think the only suggestion I would have is I think that in addition to the chronic care issue, that it probably would be helpful to have HEDIS and the data research center develop

and include some report card mechanism to measure things that relate to health status of seniors.

Second, I think health education should include not only how the system works but also some of the strategies that individuals can carry out in terms of improving their own health status.

Dr. OSHEROFF. Despite the current nature of our current measurement and reporting system, we would agree with performance measures specifically related to the senior population and would support the development of those programs.

I think one area where we see a lot of duplication is in external review arenas where we are visited by three different state agencies in California—HCFA, and NCQA, NURAC—and a whole parade of private companies coming in wanting to look at our quality assurance activities, all using different standards.

I know there have been some discussions at HCFA to try to gain some efficiencies by making those standards at least more consistent across-the-board and perhaps have one review or perhaps two as opposed to six or eight would be, I think, very beneficial.

Mrs. JOHNSON. I would be very interested in a simple one-pager on all the people that review you. We have really squandered billions of dollars in America over the years doing this in the hospital sector. The hospital sector is smaller than the managed care group sector. We simply cannot repeat that mistake in the managed care sector.

We may want some overlap or some checks and maybe the role of Medicare as a spot checker or whatever, or maybe looking at specific senior issues in that managed care plan. I do think this issue of overlap is an important one.

Dr. Nelson, were you about to contribute?

Dr. NELSON. Yes, ma'am. I was going to say, it would—it seems to me the appropriate Federal role is to help set parameters for us or empower us as clinicians and others to do the quality improvement work. For example, the Federal Government might help determine that these be patient oriented, that they be physician driven, that they be science based or something like that.

Empower us to do the work that is being done.

I also think there needs to be an issue of patient choice. What kind of choice does the senior want the make, not only in receiving the care, but what care they wish to receive and how?

Mrs. JOHNSON. I did think, Ms. Braun, your comment that seniors need the security of knowing they can disenroll as opposed to open enrollment which has systemic merits in terms of management of the system and cost control and things like that, was an interesting point and does also apply to this issue of oversight and quality.

It is some combination of these factors, that can enable us to provide good oversight and to focus on quality without encumbering the system. If there is one thing we have learned through the private sector, it is that quality of care can be improved and number of services covered can be expanded if we have a certain respect for the ability of the policies on the front line to manage and change themselves, and it has always been hard for government to be involved and not squelch invention and change. I am concerned about that.

Mr. Houghton, do you have any comments?

Mr. HOUGHTON. No, no questions.

Mrs. JOHNSON. I thank the panel very much for your time this afternoon, your attention, and appreciate your contribution.

Thank you.

[Whereupon, at 2:10 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

TESTIMONY OF AMERICAN CHIROPRACTIC ASSOCIATION

Thank you, Chairman Thomas, for this opportunity to testify before the subcommittee on the important issue of Medicare and private sector health care quality measurement, assurance and improvement. On behalf of the American Chiropractic Association's (ACA) 23,000 members and the millions of patients they treat every year, I am delighted that the subcommittee has decided to address the important issue of quality assurance in our nation's health care system -- especially as it relates to Medicare We are especially pleased that one of the central concerns of this hearing is the application of the research conducted by the Agency for Health Care Policy and Research (AHCPR) in the Medicare program. This is of particular interest to the ACA since the AHCPR recently published very significant and positive findings regarding the treatment of low-back pain through one of the chiropractic profession's primary treatment modalities -- spinal manipulation.

We are also pleased that the subcommittee wishes to discuss the effectiveness of current quality assurance mechanisms in the managed care portion of the Medicare program. We have great concerns about this issue, as it has been our experience that covered chiropractic benefits are routinely denied in the Medicare HMO setting. This has a decided effect on the quality of care provided through HMOs, as chiropractic services have been found to be highly cost effective with preferred outcomes.

ACA Supports Quality Standards

The ACA compliments you, Mr. Chairman, for your laudable efforts through these hearings to highlight the importance of ensuring that the highest standards of quality are observed both in the private sector health care system and in Medicare. The ACA wholeheartedly supports federal initiatives to bring common sense and rationality to a system that too often overlooks issues of quality, adherence to scientifically-based standards and appropriate measures of treatment outcomes.

In furtherance of ACA's commitment to empirically-based professional clinical standards, in 1990 it endorsed a set of clinical practice standards known as the Mercy Center Guidelines -- so named for the California location where they were developed. These guidelines specify recommended practices for the conditions that doctors of chiropractic (D.C.s) normally treat and were developed by a broad cross-section of the profession according to established consensus methods. We believe that our endorsement of the Mercy Center Guidelines demonstrates ACA's commitment to quality assurance and appropriateness of care.

To the best of our knowledge, ACA's support for a set of practice guidelines has preceded similar action by other health care professions. ACA is proud of the leadership position it has taken in this area and we would encourage our colleagues in other health care professions to join us by adopting similar approaches to combat unnecessary variation in health practices and high health care costs. Given the fact that only about 15% of all medical interventions are supported by valid evidence,[1] the health care professions bear an enormous responsibility for supporting, conducting and disseminating research on "what works best" in the diagnosis and treatment of health care conditions. The ACA wants Congress, and this subcommittee especially, to understand that it fully supports efforts to promote science-based standards of care, continuous quality improvement, accurate measures of health care outcomes and patient satisfaction surveys. We stand ready to work with you toward these goals.

Patient Satisfaction

ACA believes that patient satisfaction should be a major component of any system designed to measure health care quality and improvement. We encourage broader application of this aspect of quality assurance under federal health care programs and urge the committee to incorporate such proposals under any appropriate legislation it considers this year.

Chiropractic patients tend to be highly satisfied with the care that they receive -- a key reason

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[1] Smith R., "Where is the Wisdom: The Poverty of Medical Evidence," *British Medical Journal* 303:798-799, 1991. (Quoting David Eddy, MD, Professor of Health Policy and Management, Duke University.)

that as much as 15% of the population currently sees a chiropractor for health care services.[2] For example:

* One study found chiropractic patients were three times more satisfied with their care than were patients of family physicians.[3]

* A Gallup Survey found that 90% of chiropractic patients felt their treatment was effective while 80% had most of their expectations met.[4]

These findings on patient satisfaction compare extremely favorably with those of any other health care profession and help explain the immense popularity of chiropractic care.

Not only are patients highly pleased with the care they receive from their D.C., but chiropractic care has been proven extremely cost effective. As the subcommittee is aware, a majority of the conditions chiropractors treat pertain to neuromusculoskeletal (NMS) problems -- up to 88% according to ACA's 1994 Annual Membership Survey. In light of that fact, ACA is proud that research demonstrates high rates of cost effectiveness attributable to chiropractic care. Research indicates that D.C.s treat NMS conditions more cost effectively than do other providers. For example, a recent study found that for treatment of all NMS conditions treated by all types of providers, "chiropractic users tend to have *substantially lower* total health care costs."[5] (emphasis added) These important findings -- which have been corroborated by follow-up research[6] -- should come as no surprise, since chiropractors treat patients in a conservative drugless, non-surgical manner that helps them avoid the expensive hospital setting.

The high levels of patient satisfaction with -- and the cost effectiveness of -- chiropractic care should not go unnoticed by federal policymakers. We encourage this subcommittee to adopt policies that will help D.C.s more fully integrate into both private and public health care systems. Unfortunately, the chiropractic profession still labors under institutionalized impediments to full participation in many segments of the health care system. We fear that such impediments are based more on bias and ignorance rather than on science and empirical evidence. We are hopeful that through forums like these, Mr. Chairman, we can begin to set in motion polices that will lead to more complete assimilation.

The Importance of AHCPR Research

Since one of the main focuses of this hearing is the application of AHCPR research to the Medicare program, ACA is compelled to comment on one of that agency's most recent and perhaps most important findings. We are extremely pleased that the high quality of chiropractic care was recently re-emphasized by an AHCPR guideline on the treatment of low-back pain in adults. According to the guideline released last December, a multi-disciplinary team of researchers has determined that spinal manipulation is a *recommended and effective* form of care for the pervasive, multi-*billion* dollar a year malady of low back pain. Since low back pain will afflict 8 out of every 10 Americans at some point in their lives, we are hopeful that the guidelines will have significant implications for federal and private health policy.

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[2] United States Government Printing Office, Alternative Medicine: Expanding Medical Horizons, A Report to the National Institutes of Health on Alternative Medical Systems and Practices in the United States, NIH Pub. No. 94-066, December 1994, p. 121.

[3] Cherkin, D.C., MacCornack, F.A., "Patient Evaluations of Low-Back Pain Care," *Western Journal of Medicine*, Vol.150, November 3, 1989.

[4] Demographic Characteristics of Users of Chiropractic Services, The Gallup Organization, 1991.

[5] Stano, M, et al, "The Growing Role of Chiropractic in Health Care Delivery," *Journal of American Health Policy*, Vol.2,No.6, November/December 1992.

[6] Stano, M, "Further Analysis of Health Care Costs for Chiropractic and Medical Patients," *Journal of Manipulative and Physiological Therapeutics*, Vol.17, No.7, September 1994.

The ACA is especially pleased with the AHCPR findings since doctors of chiropractic are the leading experts in spinal manipulation, delivering almost 95% of all such services rendered in this country.[7] This is an important fact to remember -- doctors of chiropractic are the predominant practitioners of spinal manipulative therapy. To suggest that other types of health providers are performing spinal manipulation to any meaningful degree is simply inaccurate. Such procedures have never been taught in medical schools and osteopathic colleges long-ago de-emphasized courses in manipulative techniques. When spinal manipulation is needed, doctors of chiropractic are the providers of choice.

AHCPR Guidelines Warrant Changes in Federal Health Policy

Despite the AHCPR's conclusion that spinal manipulation is a preferred treatment for low back pain, Medicare and other federal programs continue to adhere to antiquated rules and regulations that erect barriers to this care. While Medicare provides coverage of manual manipulation of the spine performed by chiropractors, coverage is restricted through the requirement of a non-covered diagnostic x-ray. While an x-ray is required under the statute, if performed or ordered by a D.C., it is not covered, despite the fact that every state licenses D.C.s to perform x-rays. Thus, if a beneficiary wants spinal manipulation from a D.C., they are forced to pay for the required x-ray themselves or have it taken by some other provider that Medicare will reimburse for the service. This an obvious barrier to chiropractic spinal manipulation that has the effect of channeling beneficiaries from D.C.s to other, more expensive providers.

In our view, this structural impediment to chiropractic care contradicts AHCPR's finding about the efficacy of spinal manipulation. With D.C.s providing the *overwhelming majority* of these services, it makes little sense from a public policy perspective to discourage beneficiary access to these providers. We are working with subcommittee member Congressman Phil Crane and others to rectify these coverage restrictions and we hope that the subcommittee will see fit to incorporate remedial language in the appropriate legislative vehicle this year.

Unfortunately, Medicare is not the only federal health program that restricts access to chiropractors -- and thus to spinal manipulation. While over 85% of employer-provided health plans offer some coverage of chiropractic care, federal programs either limit or totally exclude these services. For example, not all health plans offered through the Federal Employees Health Benefits Plan system (FEHBP) provide this coverage. In fact, it has recently come to our attention that the FEHBP Blue Cross/Blue Shield plan available in the state of Georgia *specifically excludes spinal manipulation services*. In addition, under the military's CHAMPUS program no chiropractic services are available despite the fact that D.C.s are eligible to serve as commissioned officers in the military. Veterans health facilities only allow coverage of chiropractic care on the referral of an M.D. -- and there is little evidence to suggest that this ever occurs. In addition, the National Health Service Corps refuses to permit D.C.s to participate in that program despite the fact that D.C.s are educated and licensed to perform a wide range of primary care diagnostic and treatment services regularly performed by other primary care providers. And these are just a few of the most obvious examples.

If the AHCPR guideline process is to have any meaningful impact on the Nation's health care system, federal health agencies ought to adhere to the findings that it generates. Given the extent of low-back problems in society today and the multi-billion dollar cost of treating these conditions, federal health policy should encourage and facilitate the availability of chiropractic services in America's health delivery system. Unfortunately, as it now stands, such coverage is either specifically excluded or discouraged.

HMOs and AHCPR Guidelines

We are disappointed to learn that federal programs are not alone in ignoring AHCPR guidelines. Recent data indicates that only about 40% of health maintenance organizations (HMOs) have

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[7] Shekelle, PG., et al., The Appropriateness of Spinal Manipulation for Low Back Pain: Project Overview and Literature Review, RAND Corporation, Santa Monica CA, 1991.

adopted any of the various guidelines developed by the AHCPR process.[8] It is, therefore, of little surprise when one learns that 16% or fewer of HMOs offer chiropractic services,[9] since spinal manipulation services, including related diagnostic services, are hardly ever provided by any health professional other than a D.C. Given the great magnitude of evidence on the cost effectiveness of chiropractic care, it is unfathomable that the HMO industry has not seen fit to adopt the AHCPR guidelines or to provide spinal manipulation to a much greater extent.

HMOs claim to provide health care services more cost effectively than other delivery systems. Yet in light of the near total exclusion of chiropractors from the HMO industry, one wonders if factors other than cost effectiveness and enrollee well-being are behind the lock-out of these practitioners. ACA hopes that the exclusion of D.C.s from the HMO industry is not the result of the bias and ignorance of a bygone era in our Nation's health care history. If such bias still exists, however, we hope that it can be overcome by scientific processes such as those that the AHCPR research represents. If HMOs and other managed care entities are truly interested in providing quality health care at affordable costs, then they should adhere to the AHCPR low-back pain guideline by increasing the availability of spinal manipulation services. Therefore, we would strongly urge Congress to carefully oversee and review the implementation of the AHCPR low-back pain guidelines in the managed care industry.

Medicare HMOs

Unfortunately for Medicare beneficiaries, the HMO industry's failure to provide chiropractic services also extends to HMOs with Medicare risk contracts. As stated above, the only chiropractic service currently recognized as a covered physician service by Medicare is manual manipulation of the spine. Eventhough this is an extremely limited benefit, the fact remains that it is a bona fide "physician service" under Medicare Part B, and thus, all Medicare beneficiaries, including those enrolled in managed care organizations, are entitled to it. Yet, a great deal of evidence indicates that Medicare HMOs are systematically denying enrollees spinal manipulation by chiropractors. It is our opinion that HMOs are obligated under the law to provide the same level of service (i.e., *all* Part B services, including manual manipulation of the spine by a chiropractor) regardless of whether the beneficiary is enrolled in an HMO or remains in Medicare fee-for-service. There is ample legislative history supporting this view. To wit:

* "To qualify to receive payment in this way, a health maintenance organization would have to be one which provides:

  . . . .

  (2) *all* the services and benefits of both the hospital and medical insurance parts of the program; ..." (emphasis added.)[10]

* "[T]he conferees expect that *HMOs will make available*, either directly or under arrangements, *such services covered under Part A and B that would otherwise be available to beneficiaries in an area in the absence of HMOs.*" (emphasis added.)[11]

* "Each competitive medical plan *must provide to its Medicare enrollees at least the health services listed under Parts A and B of Medicare* which are available to individuals residing in the geographic area served by the plan." (emphasis added.)[12]

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[8] Bernstien, A., et al., 1994 HMO Performance Report, Group Health Association of America, p. 10.

[9] Marion Merrell Dow Managed Care Digest/HMO Edition 1993, p. 23.

[10] H.R. Rep. No. 29-231, 92 Cong. 2d Sess., reprinted in 1972 U.S. Code Cong. & Admin. News 4989, 5078.

[11] Conf. Rep. No. 92-1605, reprinted in 1972 U.S. Code Cong. & Admin. News 5370, 5385-86.

[12] S. Rep. No. 97-494, 97th Cong. 2d Sess., reprinted in 1982 U.S. Code Cong. & Admin. News 781, 810-11.

In view of the fact that D.C.s are the primary deliverers of spinal manipulation services, that spinal manipulation by a chiropractor is a lawful Medicare Part B physician service, and that HMOs are required to offer all Part B services, it is an outrage that Medicare beneficiaries enrolled in managed care organizations continue to be denied this service. Regardless of whether HMOs are legally required to provide this service -- which we believe they are -- the new AHCPR low back pain guideline makes it is more clear than ever that, *from both a public policy and health care quality point-of-view*, Medicare HMOs ought to be providing spinal manipulative services. With the subcommittee's interest in promoting quality health care services within these organizations, we feel that clear, congressional directive language is necessary to require Medicare HMOs to comply with the law, and the AHCPR low-back pain guideline, by providing spinal manipulation services via chiropractors.

Managed Care Coalition

As managed care's emphasis on containing costs has grown, the ACA and other health care organizations have become increasingly concerned about fundamental issues of consumer choice, access and quality. Health care consumers, including Medicare patients, deserve a certain level of protection against managed care's shortcomings in these areas. Public desire for these protections was quite evident during last year's health reform debate when several bills contained important consumer protection provisions.

Over the last several months, ACA has been working within a coalition of health providers and consumers to develop a legislative package designed to improve consumer choice and health care quality in managed care settings. The package seeks to build on the current managed care system in the following ways:

* ensure an adequate choice and mix of types of health providers;
* improve the quality and availability of plan information for consumers;
* create grievance procedures for consumers unhappy with a plan's services;
* establish 'due process' provisions for providers; and
* establish quality assurance mechanisms.

The package has a strong focus on health care quality. Current and prospective health plan enrollees would be guaranteed access to a whole new range of information on coverage provisions, benefits and exclusions, the amount of premiums set aside for administration and marketing of a plan versus the percentage spent on the provision of health care, the ratio of enrollees to providers, any financial arrangements or incentives that would limit services offered, enrollee satisfaction statistics, and quality indicators for the plan and its providers. In addition, the proposal would require the Secretary of Health and Human Services to encourage health plans to adopt quality assurance and quality improvement mechanisms and to encourage further conducting of outcomes research.

We feel that these specific elements of our coalition's package -- by vastly improving consumers' knowledge about their health plans -- will result in continuous quality improvement in managed care. Empowering health care consumers with such information will help drive health plans to make decisions based on enrollee health care needs more so than on financial considerations. In our view, the protections and information disclosure requirements contained in our proposal should be extended to all managed care enrollees including Medicare beneficiaries. We hope that the subcommittee will give serious consideration to this package of consumer friendly provisions as part of any Medicare legislation considered this year.

TESTIMONY OF HON. JAMES V. HANSEN
A REPRESENTATIVE IN CONGRESS FROM THE STATE OF UTAH

Mr. CHAIRMAN, I appreciate the opportunity to submit testimony on behalf of *HealthInsight*, the medicare peer review organization (PRO) for Utah and Nevada.

This organization has provided quality improvement services for Medicare and Medicaid since 1974. However, over the last five years, *HealthInsight* has devoted significant energy to help HCFA understand that improving quality in health care is more than just finding the bad apples in the system. As a model in the PRO community, this organization has worked to find more effective and efficient uses of federal dollars in assuring health care quality is maintained and improved.

One recent study, involving McKay Dee Hospital and physicians from my district, looked at radical prostatectomies in men age 75 and older. *HealthInsight* hypothesized from available data and medical literature that this procedure is over utilized in men over age 74. So, rather than impose regulations or penalties, they brought Utah urologists and other health professionals together as a team to discuss the diagnosis and treatment of prostate cancer. There are generally three management options given to a man who is diagnosed with localized prostate cancer: (1) radical prostatectomy - a major surgery, (2) radiation therapy, and (3) conservative observation management - watchful waiting.

Currently, radical prostatectomy and radiation therapy are the most common forms of treatment. But we all know each presents the risk of long-term complications that some of us would view as diminishing our quality of life (incontinence and impotence). The watchful waiting approach is considered when an individual has a life expectancy of ten years or less. Because localized prostate cancer grows very slowly, older men are very likely to die of other causes before cancer has any effect on their health. And those who choose watchful waiting avoid the risks of possible side effects associated with other treatment.

Information about these treatment options was sent to the medical community. The project team recommended that the underlying principal in managing disease must be <u>informed patient choice.</u> The team also recognized that radical prostatectomy or radiation therapy in patients 75 or older customarily should be <u>unusual</u> treatment options. Then, Utah surgeons and urology specialists were sent 1991-1992 prostatectomy rates for their own practices -- the data showed them their proportion of radical prostatectomies in patients over 74 compared to other physicians in the state. They were also shown a county by county comparison for the state of Utah.

Since that project was completed, 1993 and 1994 data show a significant decrease in the number of radical prostatectomies performed on men over age 74. These data show that if the rate of radical prostatectomies had continued to grow at the expected rate, consistent with the 91-92 numbers, approximately $9.4 million MORE would have been spent on this procedure in Utah alone during those two years. This example hints at the potential of community-wide improvement projects to protect health, improve the patients outcomes, and save valuable health care dollars.

As we examine ways to save federal dollars, yet maintain a level standard of care, we need to take a look at the work of *HealthInsight*. They provide significant benefits, not only to federal health programs, but to our communities at large. Through collaborations with state government, providers, consumers, insurers, researchers and others, *HealthInsight* works to ensure ongoing improvement in the quality and effectiveness of care delivered in Utah and Nevada. PRO's aren't just looking for the bad apples any longer-- they are bringing the professionals together on multiple projects to improve everyone's care.

This approach to quality management helps local health care providers come together and share valuable knowledge. Such relationships create trust and stability within our system and allow for a better transfer of information. And that translates into better care for me and you. Personally, I would rather have my physician respond to community efforts to improve care than grudgingly treat me according to a mandate from the federal government.

Mr. Chairman, *HealthInsight* is working within the PRO community to share their knowledge and promote more effective ways to meet their federal contractual obligations. As a fiscal conservative, I support federal contractors who honor their agreement and work to improve a system, rather than gouge it. As you review the PRO program, I urge you to consider the positive impacts *HealthInsight* has had in the community as well as the effective and efficent manner federal dollars have been utilized in assuring health care quality is maintained and improved.

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