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MEDICARE

Private-Sector and Federal Efforts to Assess Health Care Quality

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Medicare: Private-Sector and Federal Efforts to Assess Health Care Quality

Messrs. Chairmen, Madam Chairwoman, and Members of the Caucus:

The Health Care Financing Administration (HCFA) now estimates that 4.3 million Medicare beneficiaries are enrolled in health maintenance organizations (HMO), and enrollment is growing at a rate of about 100,000 new members per month. I am pleased to be here today to discuss ways to ensure that quality of care is furnished to Medicare beneficiaries joining these HMOs. Like large private-sector purchasers of health care, HCFA, which administers Medicare, finds the potential for cost savings associated with managed care attractive. But stakeholders—HCFA, private-sector purchasers, and others, such as individual consumers—are concerned that the cost control strategies HMOs use could lead to diminished quality of care. As a result, stakeholders are interested in programs that protect consumers from cost reduction strategies that might adversely affect their health care.

Today, I will discuss the following four areas related to quality assessment:

- quality assessment methods used by large corporate purchasers of health insurance from HMOs,
- quality assessment methods used by HCFA in administering the Medicare HMO Program,
- quality assessment methods HCFA plans for the future, and
- what both corporate purchasers and HCFA are doing to share the information about quality with employees and Medicare beneficiaries.

This statement relies on two of our recent reports, titled Medicare: Federal Efforts to Enhance Patient Quality of Care (GAO/HEHS-96-20, Apr. 10, 1996), Health Care Reform: “Report Cards” Are Useful but Significant Issues Need to Be Addressed (GAO/HEHS-94-219, Sept. 29, 1994), and other past reports on related issues. (A list of related GAO products appears at the end of this testimony.) We have also included information drawn from the results of a 1996 report of 384 U.S. employers surveyed by Watson Wyatt, a benefits consulting group, and the Washington Business Group on Health (WBGH).¹

In brief, two quality assessment methods—accreditation and performance measurement monitoring—are used by large corporate purchasers to ensure that HMOs they contract with furnish quality care. Approximately 60 percent of such purchasers consider HMO accreditation before they contract with the HMO and then require periodic reaccreditation thereafter.

¹Reality Check: Is Cost Everything? WBGH and Watson Wyatt Worldwide (Washington, D.C.: 1996).

Approximately 54 percent continually monitor certain performance indicators such as immunization rates, mortality from certain procedures, and patient satisfaction. Although these strategies are the best available to date, possible data and other limitations make them less than perfect, according to recent research.

Like corporate purchasers, HCFA is now using similar methods to ensure quality within risk contract HMOs. First, as part of its HMO Qualification Program, HCFA performs initial and subsequent reviews similar to accreditation. Second, through its Medicare Peer Review Organization (PRO) Program, HCFA collects and evaluates performance indicators for certain procedures or diseases to assess HMO performance. Although these are reasonable approaches to assessing quality, we have reported that HCFA has failed to aggressively enforce legal and regulatory requirements for its risk contract HMOs.

HCFA is now enhancing its quality assessment methods by strengthening its collaboration with the private sector to jointly develop better performance indicators for the health care needs of older Americans. Furthermore, HCFA is placing more emphasis on improving the care all HMOs provide, regardless of their prior performance, rather than focusing only on the few providing substandard care. In addition, HCFA is developing a survey tool to measure beneficiaries' satisfaction with HMO performance.

Individual consumers have expressed interest in information describing the quality of care they might obtain from different HMOs. Some corporate purchasers are distributing HMO performance information to their employees to help them choose the HMO suited to their needs. For example, 47 percent distribute patient satisfaction survey results, 31 percent distribute information about accreditation status, and almost 6 percent distribute the results of condition-specific outcome indicators. Although HCFA does plan to distribute information to Medicare beneficiaries about plan performance, the timetable for doing so is uncertain.

Background

Quality in health care is difficult to define because different stakeholders look for different attributes. The following attributes, however, are those that most stakeholders agree define the concept of quality.

- appropriateness: providers giving the right care at the right time, such as identifying and treating an infection with effective medication;

- technical excellence: furnishing the care in the correct way, for example, performing open-heart surgery skillfully;
- accessibility: patients being able to get care when needed, for example, getting an appointment with a heart specialist when symptoms first occur; and
- acceptability: patients' views of their care, such as being satisfied with the outcome of surgery or the speed with which they get a doctor's appointment.

Accreditation and analysis of performance indicators are methods for gauging whether and to what degree quality health care is provided. Accreditation does not directly measure quality, however; instead, it seeks to ensure that organizational systems necessary to attain quality are in place. Accreditation, a formal designation granted by a third party, is usually based on standards that specify the resources and organizational arrangements needed to deliver good care. For example, standards might set forth staff qualifications or the requirement that an HMO have an effective quality assurance program. During an accreditation survey, a survey team reviews an organization's policies and procedures and visits the provider to make certain that the standards are being met. The survey team discusses the survey findings with appropriate provider officials and subsequently prepares a written report. If standards are not being met, the HMO usually is given time to take corrective action. If the HMO does not take action within a specified time period, it could lose its accreditation.

Performance indicators more directly measure the attributes of quality than does accreditation. Performance indicators frequently measure appropriateness and technical excellence—providers' actions—and the outcomes of those actions. For example, these indicators provide information about the rate at which certain preventive health care actions are furnished, the mortality rate from certain procedures, or patient satisfaction survey results. Administrative databases, medical records, and patient surveys provide data for measuring these indicators. The results are then compared with preestablished benchmarks or with the performance of other HMOs.

Historically, health care providers considered confidential the specific information in an accreditation report and the results of performance indicators. Such information was rarely distributed to purchasers and the general public. Since the mid-1980s, however, some large corporate purchasers have been requiring HMOs to furnish this information before contracting or renewing their contract. Some individual consumers are

also requesting information on health plans to help them make their health care purchasing decisions.

Quality Assessment Methods Have Limitations

Some purchasers believe that the standards required to be met for accreditation might have no bearing on whether quality of care is actually furnished. Others view accreditation requirements as a way of ensuring that systems expected to result in quality care are in place. Because accreditation standards do not directly measure quality, however, many purchasers use a combination of accreditation and an analysis of performance indicators, including outcomes.

Although the use of performance indicators to assess quality has become popular, they present the following problems:

- Information reported about performance may be unreliable. Data sources for performance indicators range from large computerized administrative databases maintained by HMOs to individual patient medical records kept in providers' offices. These sources may be inaccurate, incomplete, or misleading, however, because most administrative databases were designed for financial—not clinical—purposes, and providers may knowingly or unknowingly place incorrect information in medical records or not document certain interventions.
- Indicators may not be valid measures of quality. Indicators measuring organizations' structures and providers' actions are often used when assessing quality because they are relatively easy to measure. Research has not clearly demonstrated correlations, however, between some common indicators and quality of care. For example, the rate of hospital-acquired infections has for a long time been almost universally used as an indicator of hospital quality of care. Many studies show a strong link between such infections and increased morbidity and mortality. However, the relationship between this infection rate and the quality of care in the hospital is unclear. The risk of acquiring an infection in the hospital may be more closely related to patient factors such as underlying disease, severity of illness, age, and sex.
- The reason for a given outcome may be difficult to determine. Risk adjustment systems have not been perfected, and tests of systems that are in place indicate that they may not be reliable. Outcome measures should be adjusted so that differences can be attributed to either the quality of care furnished or to patient characteristics such as age, behavior, or the presence of other diseases. If such adjustments are not made, providers

may contend that poor outcomes are due to their caring for sicker patients.

- Performance indicators may not be comparable. Nationwide standards for defining and calculating indicator results have not been established. While relying to some extent on several standard indicators, many health plans continue to use their own criteria for collecting data and computing results. Consequently, purchasers cannot systematically compare health plans to determine which one meets their needs.

Corporate Purchaser Quality Assessment Methods

Cost continues to be an overriding concern to virtually all corporate purchasers. However, many large corporate purchasers are using accreditation status and information about specific quality-of-care performance indicators to determine which HMO(s) to offer their employees. According to a recent survey of 384 U.S. employers conducted by Watson Wyatt, a benefits consulting organization, and WBGH, 60 percent of large corporations² consider accreditation status by the National Committee for Quality Assurance (NCQA) when deciding to purchase health insurance from an HMO.³ Nineteen percent also consider accreditation from other organizations. Furthermore, some purchasers evaluate other organizational structures. For example, 55 percent said they evaluate whether a health plan has quality improvement initiatives, and 67 percent determine that the health plan ensures that its providers are qualified.

Some large purchasers also use the results of specific performance indicators to track providers' actions or their performance outcomes. In the early 1990s, corporate purchasers, interested in accountability and buying quality health care, started to request specific information about HMOs' performance. The Health Plan Employer Data and Information Set (HEDIS), developed under the auspices of NCQA in 1993, was a major attempt to collect standardized information on quality of care furnished by HMOs. These first HEDIS indicators of HMO activities addressed quality, access and patient satisfaction, membership and utilization, finance, and HMO management. The indicators addressing quality issues generally focused on providers' actions and not the outcomes of those actions. For example, the rate women received a mammography exam is calculated but not the 5-year survival rate of women diagnosed with breast cancer. According to the Watson Wyatt/WBGH survey, 54 percent of large employers use HEDIS to

²A large corporation is defined by the survey authors as one that has 10,000 or more employees. One hundred twenty-three large corporations responded to this survey.

³NCQA accredits only HMOs. Other organizations accredit managed care organizations that are not HMOs.

help gauge the quality of care provided by health plans, and 68 percent evaluate the results of consumer satisfaction surveys.

NCQA recognized the need for outcome indicators when it released its first HEDIS measures. In July 1996, it released for public comment a new draft version of 75 HEDIS measures based on the recommendations of purchasers, HCFA, and other stakeholders. This new version, which NCQA expects will be used by health plans in 1997, includes a revision of prior HEDIS indicators, a standardized patient satisfaction survey, and more indicators for high-prevalence diseases. The clinical care measures continue to focus on providers' actions, however, rather than outcomes. NCQA also released another 30 indicators, a few focusing on outcomes. NCQA defines these indicators as a "testing set" to be used by health plans only after evidence has been established that certain criteria are met, such as that the indicator is a valid measure of what it is intended to assess.

While NCQA was developing new HEDIS measures, a large group of corporate purchasers and HCFA established the Foundation for Accountability (FAcct) to develop standardized outcome measures. In early fall 1996, the Foundation released eight indicators for treating diabetes, breast cancer, and major depression. Some of these measures focus on outcomes. The Foundation also endorsed an indicator addressing consumers' satisfaction with health plans.

Xerox, a large corporate purchaser, provides an example of a purchaser's use of quality assessment methods. Xerox's stated objective is to increase the accountability of health plans contracting with it and to improve the health status of its employees. Xerox officials review health plan reports about the plan's accreditation status, results on HEDIS performance indicators, access to services, and membership satisfaction. Reports also include goals for each measure as benchmarks. Xerox's goal is to develop long-term relationships with health plans. To this end, Xerox encourages health plans' continuous improvement rather than immediately terminating a contract if a plan does not meet specific performance goals.

Continuous Quality Improvement

In addition to assessing performance, some large purchasers require that HMOs with which they contract focus on continuous quality improvement. Under this approach, attempts are made to identify and establish excellent care by focusing attention on inappropriate variation in the quality of care furnished to identified populations and eliminating the variations. This approach tries to consistently improve all plans' performance, regardless

of prior performance. In the past, quality assurance programs focused on the care provided to individual patients, directing improvement activities toward individual “outlier” providers rather than encouraging improvement by health care providers. These efforts were limited to a small number of providers and often resulted in adversarial relations between the reviewers and those being reviewed.

HCFA’s Quality Assessment Methods for Medicare Risk Contract HMOs

Like other large corporate purchasers, HCFA uses an inspection process and analysis of performance indicators to evaluate the quality of care provided to Medicare beneficiaries in risk contract HMOs. HCFA’s HMO Qualification Program is intended to ensure that HMOs with Medicare contracts meet minimum requirements for organizational structures and processes. HCFA’s Medicare PRO Program is intended to measure an HMO’s performance by evaluating indicators for selected diseases or procedures of concern to older Americans.

HMO Qualification Program

Like accreditation, HCFA’s HMO Qualification Program is an inspection method. HCFA’s initial approval of an HMO to serve Medicare beneficiaries includes this inspection. Thereafter, HCFA personnel visit contracting HMOs at least once every 2 years to monitor their compliance with requirements. HCFA’s inspection team spends several days at the HMO comparing the HMO’s policies and procedures with Medicare requirements. The team informs the HMO of its preliminary findings at the end of the visit and later prepares a formal report. If the HMO has failed to meet one or more requirements, it must submit a corrective action plan, including a timetable for correcting the deficiency. HCFA personnel may revisit the site to monitor compliance at the end of the time period specified in the plan’s timetable or may simply require regular progress reports. If the HMO fails to correct the deficiency in a timely manner, HCFA may terminate its contract or, under some circumstances, impose a civil monetary penalty or suspend Medicare enrollment.⁴ This happens rarely, however, and only after repeated HCFA efforts to get the HMO to correct the deficiencies.

In the past, we have criticized HCFA for failing to aggressively enforce Medicare’s HMO Qualification Program. In 1988 and again in 1991, we found that HCFA’s efforts to obtain corrective action from a few noncompliant HMOs were mainly ineffective, even though HCFA repeatedly requested such

⁴The Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) generally broadened the circumstances under which HCFA may apply civil money penalties and suspension of enrollment. These changes are effective in contract years beginning on or after January 1, 1997.

action.⁵ Furthermore, HCFA often found that the same problems existed when it made its next annual monitoring visit. In our August 1995 report, we found the same problems.⁶ We concluded that HCFA's HMO Qualification Program is inadequate to ensure that Medicare HMOs comply with standards for ensuring quality of care. Specifically, this program remains inadequate because HCFA does not

- determine if HMO quality assurance programs are operating effectively,
- systematically incorporate the results of PRO review of HMOs or use PRO staff expertise in its compliance monitoring, and
- routinely collect utilization data that could most directly indicate potential quality problems.

We also found that the enforcement processes are still slow when HCFA does find quality problems or other deficiencies at HMOs that do not comply promptly with federal standards. For example, even though one HMO repeatedly did not meet standards during a 7-year period and HCFA received PRO reports indicating that the HMO was providing substandard care to a significant number of beneficiaries, HCFA allowed the HMO to operate as freely as a fully compliant HMO.

Medicare PRO Program

Like large corporate purchasers' analysis of performance indicators, the Medicare PRO Program analyzes HMO performance treating certain diseases or performing selected procedures. The PRO Program, however, is substantially changing its approach.

Historically, the PROs examined both inpatient and outpatient medical records of a random sample of beneficiaries to identify and correct substandard providers. If the PRO found indications of poor practice, it contacted the responsible provider to give it the opportunity to explain these circumstances. If the PRO found continuing problems and the provider would not or could not correct an identified poor practice, the PRO could recommend that the Department of Health and Human Services' Office of the Inspector General impose a sanction ranging from development of a corrective action plan to suspension of eligibility to receive reimbursement from Medicare. This PRO Program was criticized by providers and other health care experts because relatively few

⁵Medicare: Experience Shows Ways to Improve Oversight of Health Maintenance Organizations (GAO/HRD-88-73, Aug. 17, 1988) and Medicare: HCFA Needs to Take Stronger Actions Against HMOs Violating Federal Standards (GAO/HRD-92-11, Nov. 12, 1991).

⁶Medicare: Increased HMO Oversight Could Improve Quality and Access to Care (GAO/HEHS-95-155, Aug. 3, 1995).

substandard providers were identified; HCFA officials found this model to be confrontational, unpopular with the physician community, and of limited effectiveness.

Therefore, by the end of 1995, case reviews had been replaced by cooperative projects modeled on continuous quality improvement concepts implemented by mutual agreement between PROs and risk contract HMOs.⁷ Provider participation is voluntary. Typically, these cooperative projects involve establishing joint identification of a problem, appropriate performance indicators, and benchmarks. The PRO then measures current HMO performance on these indicators and disseminates these data to the HMOs. HMOs then may choose to participate in the project to improve care. After implementation of corrective action, the PROs again collect data to determine if improvements have been made.

Although this process is voluntary, HCFA officials say that they believe most HMOs will welcome the opportunity to collaborate on projects that can improve the quality of care. They do not believe that provider noncooperation will be a significant problem. HCFA officials told us, however, that they still can take action if they have strong indications that an HMO has significant quality-of-care problems. If an HMO refuses to cooperate, HCFA can still apply a range of sanctions, including a letter terminating the HMO's participation.

In one state, we talked with HMO and PRO officials about this new approach. The HMOs liked it, particularly the fact that the PRO provided them with comparative performance data that would be otherwise unavailable to them. PRO officials also felt that this program was more successful than case review because it addressed the care being provided to the majority of beneficiaries rather than the 1 or 2 percent who may be recipients of bad care. Although we think this new approach holds promise, it is too early to evaluate its impact. But an evaluation of this program as soon as feasible is essential because it is such a major departure from previous PRO practice.

New HCFA Quality Assessment Initiatives

To minimize the administrative burden on health plans and develop more valid, reliable, and comparable performance measures, HCFA is collaborating with private-sector purchasers to develop standardized

⁷Individual case review continues only for a few mandatory categories such as beneficiary complaints of poor quality care, potential cases of grossly poor care or unnecessary admissions identified during project data collection, and notices of noncoverage issued by hospitals or managed care plans.

performance indicators. HCFA also plans to collect data on beneficiaries' satisfaction with risk contract HMOs.

Development of Performance Measures

In June 1995, HCFA announced that it was joining FAcct. According to HCFA, it has played a major role in developing the Foundation's performance indicators for depression, breast cancer, and diabetes. Furthermore, HCFA worked with NCQA on its new HEDIS indicators. HCFA played a role in identifying and defining seven newly released indicators that measure functional status for enrollees over age 60, mammography rates, rate of influenza vaccinations, rate of retinal examinations for diabetics, outpatient follow-up after acute psychiatric hospitalization, utilization of certain appropriate medications in heart attack patients, and smoking cessation programs.

HCFA also plans to conduct a survey of Medicare beneficiaries enrolled in managed care. It is developing a survey instrument in cooperation with the Agency for Health Care Policy and Research. Data collected in this survey will include information on member satisfaction, perceived quality of care, and access to care. HCFA officials told us that they plan to have an outside contractor perform annual surveys of a statistically valid sample of Medicare enrollees in every HMO with a Medicare contract. The contractor will use a standard survey and provide a consistent analysis of the information received from beneficiaries.

Disseminating Quality Assessment Results to Employees and Medicare Beneficiaries

Some large corporate purchasers are sharing performance assessment information with their employees. They believe that individual employees can better choose health plans if they have good information on which to base their enrollment decisions. According to the Watson Wyatt/WBGH survey, 31 percent of large corporate purchasers give their employees information about accreditation status, 25 percent give their employees information about overall health plan performance, 13 percent give their employees HEDIS information, and 47 percent distribute consumer satisfaction survey results. Additionally, 32 percent of the large purchasers surveyed offer financial incentives to their employees to choose plans that they have designated as being of "exceptional quality."

The California Public Employees' Retirement System (CalPERS) is an example of a large purchaser providing performance information to individuals to help them select a plan that meets their needs. Although it had furnished some comparative information to its employees in previous

years, that information generally featured premium and benefits coverage. CalPERS' May 1995 Health Plan Quality/Performance Report was its first effort to distribute comprehensive information that includes both specific performance indicators about quality and member satisfaction results. The quality performance data are based on HEDIS indicators measuring HMO success with providing childhood immunizations, cholesterol screening, prenatal care, cervical and breast cancer screening results, and diabetic eye exams. Employee survey results include employee satisfaction with physician care, hospital care, the overall plan, and the results of a question asking whether members would recommend the plan to a fellow employee or friend. CalPERS released a new report providing updated information in 1996.

Although HCFA collects performance information that could be useful to beneficiaries, it does not routinely make such information available to them nor does it have immediate plans to do so. HCFA does not distribute the results of its HMO Qualification Program nor does it distribute information it collects about Medicare HMO enrollment and disenrollment rates, Medicare appeals, beneficiary complaints, plan financial condition, availability of and access to services, and marketing strategies. However, HCFA officials have told us they are considering ways to provide Medicare beneficiaries with information that will help them choose managed care plans. HCFA is working to make comparative information available on the Internet. Phase one of this project, to be implemented in 1997, will provide comparative data about HMO benefits, premiums, and cost-sharing requirements. Later phases will add information on the results of plan member satisfaction surveys and, eventually, outcome indicators. No timetable has been established, however, for disseminating the latter information.

In conclusion, large corporate purchasers who rely on experts in the field are the leaders in health care quality assessment. Although HCFA's current quality assessment programs are catching up with those of large corporate purchasers, some areas need further improvement. Most notably, HCFA still lags behind the private sector in disseminating performance assessment information to its beneficiaries.

Messrs. Chairmen and Madam Chairwoman, this concludes my formal remarks. I will be happy to answer any questions from you and other members of the Caucus.

Contributors

For more information on this testimony, please call Sandra K. Isaacson, Assistant Director, at (202) 512-7174. Other major contributors include Peter E. Schmidt.

Related GAO Products

Health Care: Employers and Individual Consumers Want Additional Information on Quality (GAO/HEHS-95-201, Sept. 29, 1995).

Medicare: Increased HMO Oversight Could Improve Quality and Access to Care (GAO/HEHS-95-155, Aug. 3, 1995).

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