

Review & Commentary on Health Policy Issues for a Rural Perspective – January 1st, 2005

Public Reporting: Arrogance vs. Indifference?

From the Commentary, “A Middle Ground on Public Accountability” by Thomas Lee et al in *The New England Journal of Medicine*, 6/3/04:

“Insurance companies and employers are posting data on quality and costs for hospitals, physician groups, and even individual physicians on their Web sites. On the other, health care providers express their outrage, citing the poor quality of the administrative claims data that are used for most of these ‘report cards’ and the failure of the analyses to adjust for socioeconomic status and important coexisting conditions. The conflict and the stakes have increased as these analyses have gone from ‘for your information’ status to incorporation into the structure of health plans and tiered premiums and copayments.”

“The payer-purchaser community admits that the data are flawed but says, ‘Don’t let perfection be the enemy of the good.’ Providers say that, too often, the data are downright misleading—and worse than nothing at all because patients and their families may be misdirected at a time of critical decision making. The payers and purchasers argue that the data are needed to ‘empower’ consumers so that they can be better ‘shoppers’ for their care. Providers see a not-so-subtle plot to justify

the shifting of costs to patients and to use flawed tools of measurement to drag prestigious but expensive institutions down into apparent mediocrity.”

“Is there a middle ground? We believe that there is, and we propose some principles that may define it. But reaching that middle ground will require each side to understand the needs and concerns of the other.”

“Limitations Of Claims Data—To be sure, there is fault to be found in the arguments of both sides in this debate. Some report-card ‘tools’ are based exclusively

on the analysis of medical claims—administrative data created for the purpose of getting bills paid, not for performing research into health services. Studies of the accuracy of medical claims are discouraging. Other research has shown that coding of chronic diseases and coexisting conditions as ‘secondary diagnoses’ is highly variable, leading to counterintuitive findings in many analyses. No wonder, then, that the hospital-ratings system used in one Internet report card on health care performed poorly as a discriminator between any two individual hospitals, as compared with measures of

quality based on detailed chart review.”

“If claims data are often inaccurate, but randomly so, then analyses based on them are biased toward the null hypothesis—which would tend to make excellent providers and sub-par providers drift into the middle of

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"I'll drop 'don't let perfection be the enemy of the good' when you stop saying 'just trust me.' "

the pack. Even more disturbing to providers is the lack of adjustment in the analyses for systematic biases, such as those due to socioeconomic status or referral patterns. For example, rankings based on mortality data that were recently published in the Boston news media suggested that the top four local hospitals for care of acute myocardial infarction were community institutions, none of which perform cardiac surgery. This analysis did not take into account the fact that these institutions routinely (and appropriately) transfer their patients at highest risk to tertiary care hospitals for immediate catheterization and revascularization. These tertiary care institutions, of course, fell farther down in the ranking. Such methodologic problems are even more severe when report cards attempt to measure the performance of individual physicians.”

“Whatever their faults, these report cards do not suffer from a lack of effort or expertise. They are based on sophisticated tools designed to adjust for the severity of illness and capture a hospital’s ability to rescue the sickest patients. But from the perspective of health care providers, who have high standards for the quality of information given to individual patients, the analyses too often challenge common sense. The companies behind these report cards are under tremendous pressure to deliver a list that places providers in some kind of order—and they do not let weaknesses in the data stand in the way.”

“Resistance From Providers—The providers’ positions have problems, too. Many physicians would like

to turn back the clock, arguing that the only reliable source of information for patients is their doctors. In truth, patients have never relied solely on their physicians for guidance on where to go and whom to see. And any individual physician’s knowledge of where a patient can receive the best care is limited.”

“We live in an era in which ‘empowered’ consumers demand transparency and will not tolerate a patronizing perspective from physicians. As patients bear an increasing proportion of their health care costs, they are likely to want to know whether evidence exists to support higher charges for the care provided by some hospitals and physicians. Consumer advocates argue that patients should have the right to see analyses, no matter how weak in methodology, as long as the patients have been informed about the weaknesses.”

“Providers also have a practical reason for their reluctance to embrace public accountability for quality and efficiency, one that recalls the football adage about the dangers of passing the ball, three things can happen, and two of them are bad. Similarly, when any report card is issued, three things can happen to providers: they can appear to be better than, on a par with, or worse than their competitors. Since most patients believe that their doctors and hospitals are better than average, the risk of losing patients’ confidence is, well, better than average.”

“Risks And Benefits Of Public Reporting—Payers and purchasers often try to calm providers by asserting, ‘No one looks at these data anyway.’ In fact, there is evidence to support the belief that the report cards are too complex for most consumers and rarely influence patients’ decisions about which doctors to see and where to be admitted for procedures. Data from Pennsylvania, for example, indicate that less than 1 percent of patients who were to undergo cardiac surgery knew the correct quality ratings for their physicians or hospitals. Such reassurances are of little comfort to providers, however, since disseminating such information is an emerging strategy for large employers, who obviously believe that patients will eventually pay attention to such information.”

“Despite providers’ mistrust of such data, there is also evidence that physicians and hospitals respond to public rankings - and that the resulting efforts to improve ratings can lead to improvements in health out-

The Rural Wisconsin Health Cooperative, begun in 1979, intends to be a catalyst for regional collaboration, an aggressive and creative force on behalf of rural communities and rural health. RWHC promotes the preservation and furthers the development of a coordinated system of rural health care, which provides both quality and efficient care in settings that best meet the needs of rural residents in a manner consistent with their community values.

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comes for patients. As physician executives in our health care delivery system, we can testify to the intense attention given to any public ranking in which our institutions appear to be only average or below average - and the high priority given to improvement if, after study, the problem appears to be real.”

“But there may be a darker side to the effects of public reporting. Because adjustment for the severity of illness with the use of claims data is far from a perfect science, report cards provide an incentive for physicians and hospitals to avoid the sickest patients. The unanswered question is whether providers respond to this incentive, consciously or otherwise. One analysis of Medicare claims data suggests that the introduction of report cards for hospitals with respect to coronary-artery bypass grafting in New York and Pennsylvania was associated with a reduction in the rates of surgery for high-risk patients, but this change was accompanied by higher net costs and worse outcomes, particularly for patients with severe conditions.”

“Is public reporting dangerous for patients—because it could lead them to the wrong doctors or wrong hospitals, or because it might subtly encourage providers to ‘game’ the system by avoiding certain patients? No one knows. There are no trials to support either hopes or fears, but both emotions have grown stronger with each recent year.”

“Defining A Middle Ground—When two sides feel so passionately about their positions, the wisdom of letting them use their power to fight it out is questionable. One side might carry the day, but the damage to health care and physician-patient relationships will last much longer. So the need for cultivation of a middle ground is urgent. We propose the following as core principles.”

“First, health care providers should give up the role of critic for that of coauthor. They should recognize that patients have a right and a need to see meaningful information about their care, and they should not argue that payers must remove these report-card tools from their Web sites. Providers should acknowledge that information itself is never inherently bad and is dangerous only if used inappropriately. Accordingly, providers should work with payers to improve the quality of these tools and to ensure that appropriate caveats about weaknesses in the analyses are on

prominent display. Focusing on the reporting of measures that have gained broad acceptance, such as the core measures used by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Centers for Medicare and Medicaid Services (CMS), is a modest but important start. Payers can facilitate the transition of providers from critics to coauthors by inviting them as early as possible into the process for designing high-quality report cards.”

“Second, payers and employers should acknowledge the limitations of current analyses, which are based on claims data, and use a multidimensional approach to reporting on quality. Structural measures of quality such as those developed by the coalition of employers known as the Leapfrog Group are more transparent and less controversial than analyses based on claims data. This group has identified several characteristics of hospitals that are associated with better patient outcomes, such as the use of computerized order entry, the presence of intensivists in intensive care units, and a higher volume of certain high-risk procedures. As the science of quality measurement improves and additional robust clinical data become available, new measures should be incorporated. In the meantime, we recommend that payers and purchasers use at least three independent approaches to the measurement of quality in any analysis of provider performance (e.g., Leapfrog, JCAHO, and CMS measures for hospitals, and data from the Health Plan Employer Data and Information Set [HEDIS] and board-certification and recertification status for physicians) and should explain to their members why the results may appear inconsistent.”

“Third, payers should use great caution as they develop tiered insurance products in which patients have to pay more for care from some providers than for care from others, either in higher co-payments at the time they receive care or in higher premiums withheld from their paychecks. We do not believe that providers should be assigned to higher or lower tiers on the basis of financial factors alone. At the very least, information on quality should be provided along with the financial implications of choosing a specific hospital or doctor. We believe that a reasonable and achievable goal is to develop approaches that assign providers to tiers on the basis of data on both efficiency and quality. For physicians, such measures might include the percentage of prescrip-

tions they write that are for generic medications and their performance on HEDIS measures. For hospitals, these measures might include the average length of stay and Leapfrog criteria such as the use of computerized order-entry systems or the use of intensivists in intensive care units. We do not believe that currently available claims-based report cards are reliable enough to be used to place providers in different tiers with regard to insurance coverage. The contributions of individual measures of quality and efficiency in the assignment of providers to tiers should be transparent to purchasers and patients so that they can use their own values to make their choices.”

“**Fourth**, the quality and efficiency of care provided by physicians should be analyzed at the group level (e.g., 10 or more physicians) with adequate adjustment for patients’ health status and other factors that are likely to influence performance. We believe that considerable danger arises from the publication of data on individual physicians or from the use of such data to include or exclude their services from insurance coverage. We think that data on individual physicians should be provided to those physicians so that they can try to improve their quality and efficiency but that these data should not be used for other purposes because the samples are too small and adjustment for severity of illness and socioeconomic status of treated patients is inadequate. Publication or other use of data on individual physicians introduces too great an inducement to physicians to avoid providing care for low-income patients or those with severe or costly conditions.”

“**Finally**, we would argue for collaboration among payers, purchasers, patients, and providers in the development of systems of public accountability. There are a large number of potential report cards available to patients with specific illnesses, and they often give inconsistent results - causing confusion among patients and despair among providers. Each payer in a region does not really need to develop its own version of a quality report card on providers. Collectively, we should try to converge on a smaller number of more meaningful measures to reduce the burden and costs of data collection. As we do so, we owe our patients clear and complete explanations of the strengths and weaknesses of the information that they are receiving. None of these measures are perfect, and we should give both doctors and patients more experience with these data

before they are used in insurance products. This experience will help patients make choices among insurance options and help physicians understand how to improve the care they provide.”

“We think these basic principles characterize a reasonable middle ground that accommodates the needs and fears of payers, purchasers, and health care providers. The ability of both sides to occupy this middle ground is likely to influence their ability to collaborate on solving other daunting issues facing health care today. After all, real progress in addressing rising costs, gaps in the quality of care, and problems with patient safety only begins with the measurement and description of the issues. Payers and providers must invest both resources and time in the systems that can improve health care - and this combined investment will occur more naturally if payers and providers do not believe they are necessarily adversaries.”

Subsequent Correspondence in *The New England Journal of Medicine*, 8/26/04:

To The Editor (from Robert Galvin et al.): “In an otherwise insightful review of the challenges of public accountability, Lee et al. (June 3 issue) fail to place the patient squarely at the center of the health care system. Patients and consumers are demanding—and deserve—information about how to choose the best doctor. One rarely hears patients ask for the ‘best medical group’ when they are ill.”

“The majority of physicians practice in groups smaller than 10, the threshold that Lee et al. chose. With the use of their rule, more than half of Americans would not have the kind of information about doctors that they want. Furthermore, performance at a group level masks much of the interphysician variation of interest to patients. Performance data must be fair and accurate; programs such as Bridges to Excellence have overcome the methodologic challenges. The ‘battle lines’ the authors describe should not be between payers and providers, but between what patients want and what stands in their way.”

To The Editor (Marc P. Volavka et al): “Many of the principles regarding a middle ground on public accountability as cited by Lee et al. already exist in Pennsylvania under the nation’s most progressive system of public reporting. We share many of the

authors' concerns but believe that the appropriate response to flawed methodology is the use of more rigorous approaches, rather than the quicksand of more middle ground offered up by the authors."

The Authors Reply (Thomas Lee et al.): "We agree with Galvin et al. that data on individual physicians can reveal important variability in practice patterns that may be masked by group-level data. In fact, we routinely use data on individual physicians in our organizations' efforts to improve quality and efficiency. However, the more widely data are disseminated, the greater the need for methodologic rigor. When data on individual physicians are reported publicly or are used to influence access in newer products and services offered by insurance plans, issues such as sample size and adjustment for the severity of illness and socioeconomic status become daunting. The issue of physician groups versus individual physicians as the unit of analysis is secondary to our concerns about the fairness and accuracy of publicly reported measures of quality. Given the quality of administrative data that are currently available, we agree that a good approach to these methodologic challenges is that of Bridges to Excellence, which emphasizes physician-level reporting on the availability of systems such as electronic records."

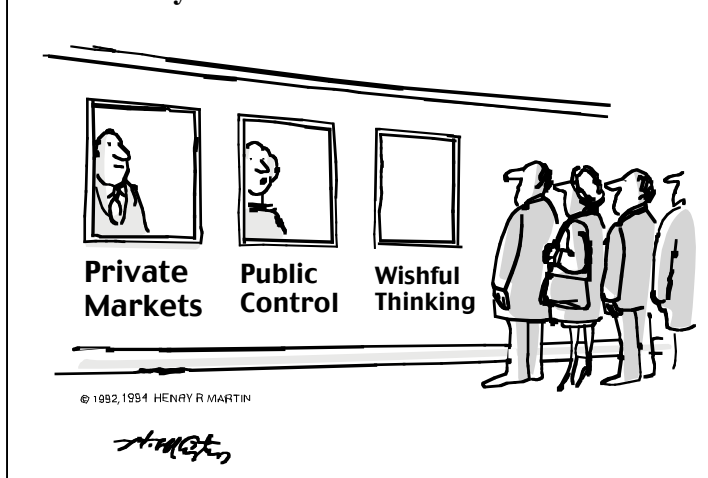
"We are pleased with Volavka and Gorton's report of growing consumer interest in the Pennsylvania CABG report card. However, we continue to be concerned that there is not sufficient volume, data, and knowledge about risk adjustment to make analogous public reporting feasible for most other areas of medicine."

Insurers Reinvent Selves or Government Will

From "Hot Potato Endgame" by Arnold Milstein in *Health Affairs*, Nov/Dec 2004:

"All stakeholders in the flow of health insurance dollars seek to improve their margin between income and spending. Facing steep rates of increase in medical costs, insurers pursued mergers that improved their bargaining power with customers and suppliers and that captured administrative economies. Both of these scale-dependent improvements increased barriers

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to entry. Insurers thrived; employers, workers, retirees, and taxpayers suffered. The 'hot potato' of margin reduction had again changed hands."

"James Robinson observes that margin improvements built on diminished competition are inherently unstable. Although predicting change in complex adaptive systems is difficult, his formulation of a two-scenario endgame for insurers is credible: rejuvenation via innovations that deliver affordability, quality, and access; or domestication in a world of publicly funded and specified health benefits."

"Private-sector rejuvenation. Large commercial insurance purchasers are actively facilitating insurer rejuvenation. Despite their increased economic pain, most are predisposed toward market solutions and believe they can effectively manage health benefit programs. Reinforcing this predisposition are surveys indicating that employees value their employer as an ally in dealing with insurers and providers."

"These efforts among purchasers center on three complementary approaches to improving the efficiency of health benefit spending: portable spending accounts, provider pay-for-performance, and tiered plans. Purchasers' three approaches fit within a simple model: (1) new insurance options that better reward providers for superior performance and enrollees for informed selection of high-performing providers and health risk-reduction behavior; and (2) a consequent compelling business case for direct and indirect providers of care to continuously reengineer, to capture efficiencies that offset the inflationary effects of increased demand for biomedical innovations and population aging."

“Portable spending accounts: The blunt instrument. Most large employers intend to add higher-deductible plan options paired with tax-advantaged health reimbursement accounts (HRAs) or newly enacted health savings accounts (HSAs). Early reported yields have been favorable: They include higher rates of health risk-reduction behavior and price-conscious service substitutions such as generic drugs and ambulatory surgeries. Most report an initial reduction of five to ten percentage points in premium growth compared with the concurrent or preceding trend, net of any reduction in plans’ actuarial value. These reports have not been confirmed by health services researchers.”

“Few large employers regard spending accounts as stand-alone vehicles for continuous improvement in health benefit efficiency. More than half of health benefit spending is for sicker enrollees, who rapidly exhaust their spending accounts and exceed out-of-pocket plan limits. These enrollees are also least amenable to switching to new plans. In addition, the RAND Health Insurance Experiment documented that giving consumers blunt incentives to avoid care impairs health because few can distinguish useful from useless clinical services. Finally, stimulating provider efficiency capture via spending accounts requires usually unavailable comparisons of provider cost-efficiency. Most large employers have not strongly motivated their enrollees to select spending accounts, preferring to monitor small-scale tests of their impact on health insurance trend, quality, and employee relations, especially for sicker enrollees.”

“Pay-for-performance: The ‘you go first’ stand-off. Long-established, cost-efficiency-based, pay-for-performance (‘P4P’) programs among health maintenance organizations (HMOs) include capitation payment, fee-for-service withholds, and bonus programs. Partly in response to purchasers’ leadership, more than sixty quality-based P4P programs have been recently implemented, mostly by insurers. While evidence is inconclusive on whether quality has improved, many attribute this to a lack of coordination among insurers, leading to divergent provider performance measures or insufficient incentives. Some purchasers remain optimistic about P4P, although its uptake remains stuck in a ‘you go first’ stand-off.”

“Most providers are wary of programs funded by reduced annual base payments or explicit penalties for

poor performance. The first attempt by the Centers for Medicare and Medicaid Services (CMS) to initiate a budget-neutral program with Premier drew a minority of eligible hospitals and skepticism from the Office of Management and Budget (OMB). Purchasers and plans facing steep cost increases are equally wary about ‘going first’ by paying more to current high performers. Purchasers with core businesses that sell clinical performance improvement services and technologies are understandably more enthusiastic. Four Leapfrog employers in New York and a GE-led group of purchasers in four communities have attempted to end the stand-off via programs in which purchasers share with providers the actuarially estimated savings from high quality. However, neither program has been applied by insurers to their insured enrollment that accounts for most insurer payments.”

“Tiered plans: The oligopoly-challenged precision tool. While many regard portable spending accounts as the defining feature of consumer-directed health plans, the predominant form is tiered benefit coverage based on the quality or cost-efficiency rating of the provider, medication, or personal health risk-reduction programs selected by enrollees. The majority of tiered plans continuously vary consumers’ cost sharing on their selections at the point of care, although some fix it annually. Examples include a lower premium or deductible in exchange for a year-long enrollee obligation to use providers in the top-rated tier exclusively. ‘Narrow network’ forms have generated percentage savings in the mid-teens; in some cases, tiered plans are combined with spending accounts to further intensify consumers’ value-consciousness.”

“Tiered plans may represent the best hope for insurer rejuvenation because they simplify employees’ identification of better-value selections and spare insurers the risks of unproven provider-improvement hypotheses or perceptibly reducing providers’ fees. However, insurers’ margins mainly depend on nontiered options; many worry that tiered plans will alienate providers and trigger fee increases or withdrawal from plans less sensitive to provider performance. Another challenge is that valid service line-specific quality and cost-efficiency measurements of individual providers and their transformation into P4P or tiered plans that ensure adequate access usually require pooling of claims data across insurers. Pooling stirs concerns that it may compromise insurers’ confidential negotiated unit

price advantages. In markets such as Massachusetts and Missouri, where insurers overcame these concerns, some oligopoly providers have refused to participate in performance-tiered plans or insisted on measurement or tiering methods that improved their tier placement. This has kindled purchasers' calls for stronger antitrust regulation."

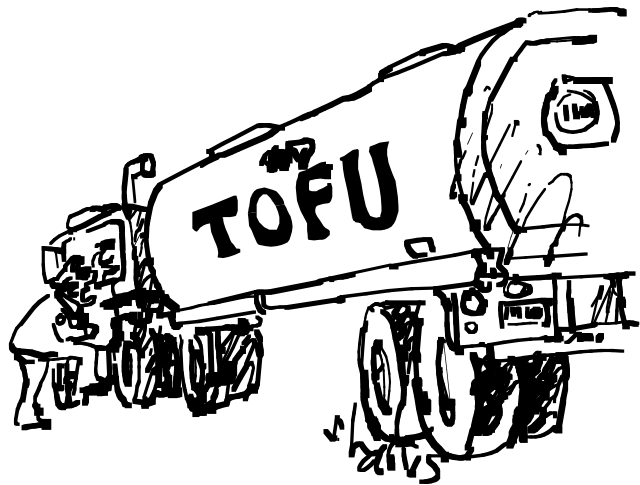
"Endgame. The insurer endgame of rejuvenation or domestication will likely be resolved by unpredictable events and other stakeholders that are indifferent to market solutions. These include U.S. economic growth rates, labor markets, providers, legislators, antitrust regulators and courts, and especially insurers' willingness to risk their inherently unstable new prosperity for a non-domesticated future. The insurer endgame is one element of a broader societal endgame also offering two alternatives: large continuous efficiency capture via robust clinical reengineering; or limiting biomedical technology's bounty to the rich. To avoid social divisiveness, more allies will likely join purchasers' quest for clinical efficiency. To avoid domestication, insurers must more robustly support this quest, especially via tiered plans that are highly sensitive to provider performance differences."

Chronic Illness & Best Community Practices

"On January 6 and 7, 2004, the Institute of Medicine (IOM) hosted the 1st Annual Crossing the Quality Chasm Summit, convening a group of national and community health care leaders to pool their knowledge and resources with regard to strategies for improving patient care for five common chronic illnesses. This summit was a direct outgrowth and continuation of the recommendations put forth in the 2001 IOM report *Crossing the Quality Chasm: A New Health System for the 21st Century*. The summit's purpose was to offer specific guidance at both the community and national levels for overcoming the challenges to the provision of high-quality care articulated in the *Quality Chasm* report." A summary is at: <www.nap.edu/execsumm_pdf/11085.pdf>.

If you are interested in reading the 176 page book; it can be purchased or read online for free on line at: <www.nap.edu/catalog/11085.html>.

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"Looks like this community health improvement thing is good for business."

Fiscal Impact of State Aging Trends

"Measuring the Years: State Aging Trends & Indicators <www.nga.org/center/databook04/> is from the National Governors Association to assist states in preparing for the challenges and opportunities they will face as baby-boomers age. A part of the NGA Center's Aging Initiative: State Policies for a Changing America, this publication is designed to identify current trends and future directions related to an aging America, and to assist state policymakers in creating programs and policies that respond to unique needs of the people in their state."

"American society is in a state of transformation. As the baby boomers continue maturing, they are changing the face of aging. This diverse group of Americans are living longer, using new technologies, extending their working years, and enjoying higher levels of income and resources than previous generations. At the same time, despite the improvements, the number of elders coping with chronic illness and disability is expected to escalate in the coming years—increasing demand on health and long term care systems and services. This data book provides a wealth of information on topics ranging from demographic shifts, to health care concerns, to long term care workforce shortages; such as:

- Between 2000 and 2025, states will experience a significant change in the proportion of elderly persons. (Relative to other states, Wisconsin is expected to become younger, going from 20th to 21st oldest. But the proportion of people over age 65 will grow from 13.1% to 20.5%.)
- Chronic disease prevention and control has become a top priority, as levels of chronic conditions increase.
- States are expected to experience dramatic workforce shortages among paraprofessionals.”

“The size of a state’s population and the population’s age distribution, labor market skills, and employment opportunities help to define the needs and resources of the state’s citizens. Changes in the population not only affect what services will be needed, but also the tax base that will be available to support needed services.”

“Anticipating the future requires understanding the complex relationships of a state’s economy and the state’s population. The simple version of the story is that the aging of society will result in a relative decline

in the need to support education and a relative increase in the need to support social services more likely to be used by older people. Changes in the population will affect not only education and health care but also safety, law enforcement, the judiciary and even prisons. The more complex story is that there will be variations among states, not only because the economies of each state vary but also because demographic changes will occur differently from state to state.”

“By far the biggest challenge of any community is to maintain community as the place where people want to live. Migration often reflects residents’ desire to leave—and usually the first people to leave are future workers and taxpayers and those who can afford to leave. Those that remain are individuals who are least likely to be able to support needed services.”

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