



COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

PUBLIC REPORTING AND TRANSPARENCY

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ABSTRACT: Interest in collecting and publicly reporting information about the cost and quality of health care has been growing. Yet questions remain about the accuracy of reported price, process, and outcome information; the comparability of results across different populations; and whether and how patients and others use the information to make decisions. Advocates for public reporting argue that it will inject competition into the health system. In addition, it could help providers improve by benchmarking their performance against others, encourage private insurers and public programs to reward quality and efficiency, and help patients make informed choices. Studies of current public reporting efforts have found that public reporting can add value, but that reports must be carefully designed. Research also shows the importance of automated and unobtrusive data collection, as well as collaboration among private and public bodies, and providers and purchasers.

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EXECUTIVE SUMMARY

For the last several years, interest in collecting and publicly reporting information about the cost and quality of health care has been growing. Yet such activities are controversial. While health care providers and payers face demands to conduct their business more transparently, questions remain about the accuracy of the reported price, process, and outcome information; the comparability of the results across different populations; and whether and how patients and others use the information in making decisions.

Advocates for public reporting argue that it will inject competition into the health system. In addition, they say that public reporting could help providers improve by enabling them to benchmark their performance against other providers, encourage private insurers and public programs to reward quality and efficiency, and help patients make informed choices about their care. There are multiple audiences for health performance information:

- *Consumers.* Consumers could use this information at various points of interaction with the health system, from the time they choose a health plan to the point of selecting a health care provider for a specific service.
- *Employers/Purchasers.* Employers may want information to use in selecting from among various health plans or self-insured options, including the cost and outcomes of providers included in a given plan's network and the plan's record of performance in meeting service and quality standards.
- *Health plans.* While health plans have access to their own claims data, in certain markets they may not have sufficient information to evaluate the price and quality of all physicians, hospitals, and other providers. Plans may also want to benchmark their performance on service and quality measures to their competitors.
- *Providers.* Hospitals, physicians, nursing homes, and other health care providers would benefit from more transparent price and quality information as a feedback loop for improved performance and for identifying the most efficient and effective referrals.
- *Policymakers.* Federal and state officials with responsibility for oversight and monitoring of system performance would benefit from accurate and timely information on providers and health plans to monitor changes in the overall system, pinpoint areas that warrant closer investigation, and encourage the reporting groups to monitor their own performance.

Health services researchers have been active participants in the development of reporting tools and are now providing feedback on how efforts to improve transparency in U.S. hospitals, health plans, nursing homes, and physician practices have fared. A number of lessons have been learned so far:

- *Public reporting adds value.* Some have argued that merely having a feedback loop that allows hospitals, physicians, or health plans to compare their own performance to reported averages, without going public, is sufficient to improve quality. Yet numerous studies point to the positive effects of public reporting. For example, public reporting of comparative data on patient satisfaction enhances and reinforces quality improvement efforts already under way, and appears to stimulate quality improvement activities in areas where performance levels are reported to be low.
- *Reports must be designed carefully.* An emerging body of research indicates that the way information is presented affects how it is interpreted and weighed in decisions.
- *Collaboration appears to be essential.* The most successful approaches to public reporting and transparency have resulted from partnerships involving the public and private sectors as well as purchasers and providers.
- *Many state and local efforts have proven successful.* State and local efforts have proven successful, in part, because the scale is manageable and local sponsors are able to account for factors that affect performance in the regional delivery system.
- *Research and evaluation have played a critical role.* The movement toward greater transparency is in its infancy, and research and concurrent evaluation have actively informed the most successful efforts.
- *Automated data collection is needed.* When data are not routinely and unobtrusively collected as part of the ongoing care process, the result is an additional burden placed on providers and health plans.

A number of legislative proposals related to public reporting and transparency were brought before the 109th Congress. Some aim to encourage transparency in the health care system by expanding the requirements for public reporting in public programs. Others seek to extend the use of health information technology and create an interoperable system for the nation. Such efforts could help to build the infrastructure needed to support public reporting. This legislation is likely to see further action in the immediate future.

PUBLIC REPORTING AND TRANSPARENCY

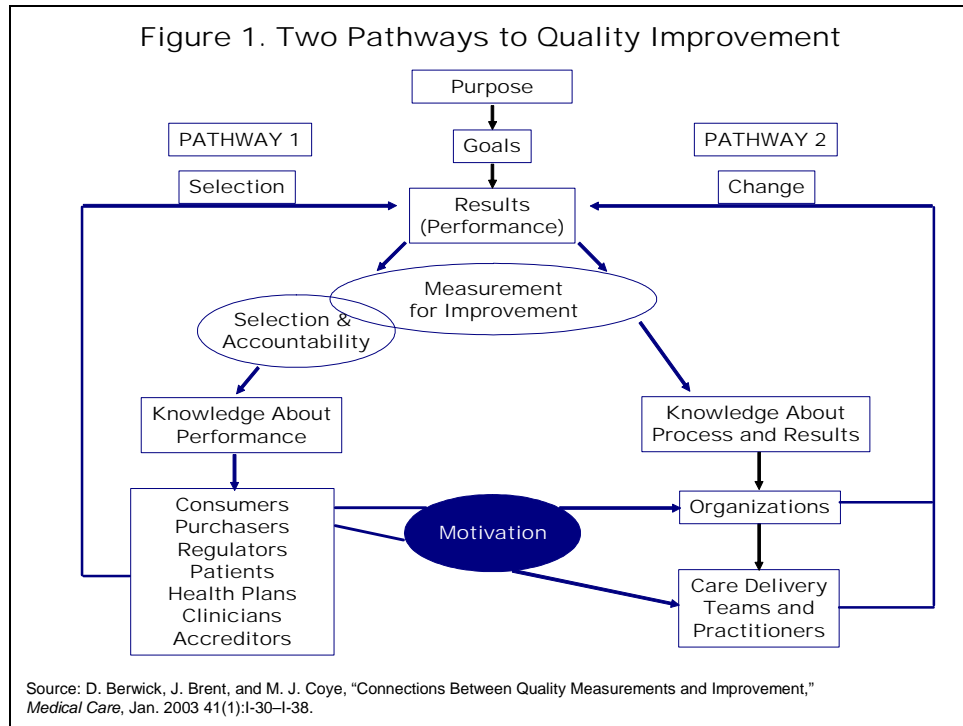
Introduction

For the last several years, interest in collecting and publicly reporting information about the cost and quality of health care has been growing. Yet such activities are controversial. While health care providers and payers face demands to conduct their business more transparently, questions remain about the accuracy of the reported price, process, and outcome information; the comparability of the results across different populations; and whether and how patients and others use the information in making decisions.

The publication of two seminal Institute of Medicine reports on safety and quality strengthened demands to measure and improve the performance of the health care system. In 1999, *To Err Is Human* identified systemic flaws in patient safety and estimated that as many as 98,000 Americans die each year as a result of preventable medical errors.¹ Two years later, *Crossing the Quality Chasm: A New Health Care System for the 21st Century* called for more transparent, safe, effective, and patient-centered care as a way to bridge the divide between the health care system we have and the high-quality system that is possible.²

To have a truly competitive market, buyers and sellers need to have access to accurate and timely price and other information. Yet the market for health care services is largely devoid of such information for patients and other consumers. Critics of the current system argue that this stifles competition, increases overall costs, and results in poorer outcomes. Others suggest that even when information is available, it fails to engage patients as active participants in their care.

Even if there were no competition in the market for health services, however, publicizing information on health system performance—much like a responsible free press—can make the health care system more accountable. Indeed, policymakers and health care purchasers advocate for public reporting with three goals in mind, in addition to promoting competition. They are: 1) to help providers improve by benchmarking their performance against other providers; 2) to encourage private insurers and public programs to reward quality and efficiency; and 3) to help patients make informed choices about their care (Figure 1).³



This issue brief provides a short history of efforts to report information on health system performance and identifies policy issues to consider when advancing such efforts. Finally, it offers lessons drawn from the experience of public reporting efforts to date.

A Brief History

In 1984, the Health Care Financing Administration (HCFA), now known as the Centers for Medicare and Medicaid Services (CMS), began to publicly report the hospital mortality rates of Medicare patients.⁴ In an effort to target their administrative oversight activities, the agency identified 269 hospitals that had significantly higher or lower death rates than predicted for Medicare patients. Although their analysis controlled for a variety of external factors, it was severely criticized, and eventually HCFA stopped publishing the so-called death list.⁵

In the early 1990s, several states began publicly reporting mortality rates for hospitals and surgeons performing open heart surgery. New York State embarked on a groundbreaking reporting of severity-adjusted mortality rates for coronary artery bypass graft (CABG) surgery by hospital and surgeon. In 1992, Pennsylvania began reporting CABG mortality rates and by 1998 the state was reporting risk-adjusted CABG mortality rates for Pennsylvania cardiac surgeons, hospitals, and 34 health insurance plans.

In 1993, the National Committee for Quality Assurance (NCQA), a private, nonprofit organization, began to report data on the quality of managed care plans drawn from the Health Plan Employer Data Information Set (HEDIS). HEDIS includes clinical measures of performance as well as results from a health plan enrollee satisfaction survey known as the Consumer Assessment of Healthcare Providers and Systems (CAHPS).⁶ NCQA has since expanded its data reporting to include Medicare and Medicaid plans as well as commercial point-of-service plans. Several states followed suit in the mid-1990s. For example, in 1995 Maryland became the first state to issue independently audited report cards on all commercial health maintenance organizations (HMOs).

In 2002, the National Quality Forum (NQF), a nonprofit membership organization created to develop and implement a national strategy for health care quality measurement and reporting, published *Serious Reportable Events in Healthcare*. This report identified 27 adverse events considered serious, largely preventable, and of concern to the public and health care providers. NQF anticipated that states or the federal government would require the reporting of such medical errors.⁷ Since then, NQF has developed voluntary consensus standards for reporting data for a broad range of health care settings and conditions.

Starting in 2002, Medicare launched a series of quality measurement and reporting initiatives that targeted different provider groups, beginning with the Nursing Home Quality Initiative and followed by the Home Health Quality Initiative and Hospital Quality Initiative. The Medicare Modernization Act and the Deficit Reduction Act reduced Medicare payment rates by 0.4 percent and 2.0 percent, respectively, for those hospitals not voluntarily reporting selected quality indicators. As a result, nearly all hospitals now submit the required information. The reporting of the clinical data will, in the near future, be supplemented by information from a consumer satisfaction survey. In 2004, Medicare's Physician Focused Quality Initiative, which includes the Doctor's Office Quality Project, was developed. Also in that year, the quality initiatives were expanded to encompass kidney dialysis facilities.

Since 2005, Aetna has made available online to its customers the exact prices it pays doctors for hundreds of medical procedures and tests. The initiative, likely to be copied by other private insurers, aims to give patients the tools to comparison shop and make savvier decisions with their health care dollars.⁸ Other private sector reporting initiatives have emerged in the last several years, corresponding to the growth of health plans with very high deductibles and other cost-sharing features that require patients to be cost conscious. More employers are offering high-deductible health plans, which have

lower premiums and tax-preferred health savings accounts.⁹ HealthGrades, a publicly traded company, uses proprietary and public databases (such as state licensure boards certification reports from the American Board of Internal Medicine, and Medicare payment files) to offer free and by subscription cost and quality reports on hospitals, physicians, nursing homes, and home health agencies. ConsumerHealthRatings.com is a clearinghouse that provides links to more than 300 organizations that rate or report performance on specific hospitals, health plans, physicians, nursing homes, home health agencies, and other health care providers.

Federal public reporting efforts were given a boost in August 2006, when President Bush signed an executive order directing all federal agencies to implement programs to measure and report the quality and cost of services to beneficiaries or enrollees of federal health care programs.¹⁰ The order assumes that these measures will be developed through collaborative efforts involving various stakeholders in the private and public sectors. Federal agencies are also ordered to develop and disseminate information on the overall costs of services for common episodes of care and the treatment of common chronic diseases. In addition, the Department of Health and Human Services is supporting pilot projects testing measures and reporting techniques in six locations and encouraging employers nationwide to join the effort.¹¹ In June 2006, CMS began to post hospital-specific charge and payment information for 30 common elective procedures and other hospital admissions on its Web site. Medicare payment information is now available at the county level for physician services, ambulatory surgery centers, and hospital outpatient departments.

Who Are the Target Audiences?

As seen from these examples, there are multiple audiences for information on cost and quality of health care:

- *Consumers.* Consumers of health care services are the most obvious audience for information on the costs and quality of care. They could use this information at various points of interaction with the health system, from the time they choose a health plan to the point of selecting a health care provider for a specific service.
- *Employers/Purchasers.* Employers act as intermediaries in selecting health insurance for most privately insured Americans. Employers may want information to use in selecting from among various health plans or self-insured options, including the cost and outcomes of providers included in a given plan's network and the plan's record of performance in meeting service and quality standards.

- *Health plans.* While health plans have access to their own claims data, in certain markets they may not have sufficient information to evaluate the price and quality of all physicians, hospitals, and other providers. Plans may also want to benchmark their performance on service and quality measures to their competitors.
- *Providers.* Hospitals, physicians, nursing homes, and other health care providers would benefit from more transparent price and quality information as a feedback loop for improved performance and for identifying the most efficient and effective referrals.
- *Policymakers.* Federal and state officials with responsibility for oversight and monitoring of system performance would benefit from accurate and timely information on providers and health plans to monitor changes in the overall system, pinpoint areas that warrant closer investigation, and encourage the reporting groups to monitor their own performance.

In this way, the release of performance data could help to hold the entire health system accountable.

Although there are obvious advantages to be gained from public reporting for each of these audiences, questions remain. For example, can the information be presented in a manner that consumers can understand and use? Will the release of public information be a sufficient motivator to change the behavior of health plans and providers? Can the data be accurately adjusted to fairly reflect differences in patient severity, demography, and other factors that may legitimately affect cost or quality?

What Are the Reporting Entities and What Information Do They Report?

A wide range of health care providers is engaged in various reporting systems.

Hospitals. Hospitals across the country are reporting information on the costs and quality of their care. In some instances, charge and net payment data are reported by case or in aggregate. Volume information, including the number of cases by type and average length of stay, is also available on certain report cards. Increasingly, results from standardized consumer satisfaction surveys are being published. A number of states are also requiring hospitals to report medical errors and near misses. As noted above, Medicare is reducing payments to hospitals that fail to report certain indicators of clinical quality. CMS has posted a Hospital Select tool on its Web site that enables users to examine a number of quality and volume measures for institutions that have voluntarily submitted such information.

Physicians. Although public reporting involving physician groups or individual physicians is not yet as pervasive as hospital or health plan report cards, there are a number of notable examples. New York and Pennsylvania have long-standing reports on cardiac surgical procedures at the individual physician level. Certain private payers are making information on physician charges available to their subscribers, particularly those with high-deductible plans and large cost-sharing responsibilities. HealthGrades sells reports on individual physicians' board certification, disciplinary action, and educational background. They also sell information on the average charge, health plan payment, and out-of-pocket costs on all the expenses related to 56 procedures, including hospital, doctor, drug, and laboratory costs. These reports also contain Medicare reimbursement levels for both hospitals and the physicians. Finally, several states, notably Massachusetts, California, and Minnesota, are reporting quality measures at the medical group level.

Health plans. NCQA's annual reporting of HEDIS information is the most extensive public reporting of health plan data. HEDIS includes standardized measures of clinical performance (e.g., the percentage of diabetics who received retinal eye exams or the percentage of patients who had a heart attack and received beta blockers for six months) and results from satisfaction survey questions (e.g., the percentage of subscribers who would definitely recommend the plan to friends or family or the percentage of members who said that getting information about the plan was not a problem). Since their appearance in the mid-1990s, health plan report cards have evolved. Some electronic versions of report cards enable users to make comparisons among specific plans and to combine several clinical measures into robust aggregate measures of performance for an entire clinical condition.

After the creation of Medicare Part D, CMS inaugurated the Medicare Prescription Drug Plan Finder on its Web site, medicare.gov. The tool prompts users to answer a series of questions about their location, current prescription drug usage, and pharmacy preferences, then generates a list of available Medicare private drug plans that can be sorted according to the total estimated annual cost, monthly premium, and other variables. For the 2007 enrollment period, CMS has added a three-star rating system that reports plan performance from 2006 in areas such as complaints, telephone customer service, appeals, and stability of drug prices.

Nursing homes. Nursing homes are required to report to state agencies, and ultimately to CMS, clinical assessment information on each nursing home resident upon admission and periodically thereafter. From this Minimum Data Set (MDS), discrete measures of care are calculated in 11 domains, ranging from nutrition and eating to

physical functioning. The CMS Web site, Nursing Home Compare, allows direct comparison of selected measures.¹² The Web site also includes information on the number, type, and severity of deficiencies found by state or federal inspectors at the time of the most recent facility inspection.¹³ Some states are also requiring that nursing homes report ratios of residents to nursing and other staff.

Home health agencies. In 2000, the federal government began requiring every Medicare-certified home health agency to submit health assessment information using a data collection tool called the Outcome and Assessment Information Set (OASIS). Since the fall of 2003, CMS has posted on its Web site a subset of OASIS-based quality performance information. Since 2005, it has included 10 measures derived from the OASIS data and endorsed by an NQF-run consensus group.

Over the years, there have been broad criticisms of the reliability of data on the cost and quality of health care. Some of the prominent issues are discussed below.

Cost and charge information. Hospital billing information is notoriously complicated and obtuse. Physician billing is not much better. Hospitals may bill for literally hundreds of discrete services or items on a single bill, depending on the severity of the admission. Patients may also receive multiple bills. Even with the information aggregated to the total charge per admission, the charges are very different from what any one payer would reimburse the hospital, and similarly very different from the hospital's cost for that admission. The average difference between the cost and charges nationally is 164 percent; on average, hospital charges are more than 2.5 times their costs.¹⁴ Hospitals' net income is not anywhere near that level because few people, if any, pay the posted amount. Medicare pays for inpatient hospital services in accordance with its prospective payment system. State Medicaid programs generally pay hospitals below their costs. Private insurers and health plans use a wide variety of payment schemes (e.g., making fixed payments per case mix-adjusted admission, payments per case mix-adjusted day, or a percent of charges). On average, private payer payments to hospitals are 24 percent above hospital costs.¹⁵ Therefore, when charge or payment information is reported, it may not be in accordance with how a particular payer will pay. Thus, even if patients know that their policy will require a copayment or a deductible, it is very difficult to estimate in advance what their financial obligations will be.

Case mix/severity/risk adjustment. In order to make sure that the reported cost or quality measures take into account legitimate differences among the types of patients treated, increasingly sophisticated case mix/severity/risk adjustment techniques have been

developed. None of them is perfect. Therefore, when hospital and physicians are reported to have higher costs or poorer quality, they will often (sometimes with justification) allege they have sicker patients.¹⁶ There is concern that failure to correctly account for case mix will result in physicians refusing to accept more complex cases. It has been suggested that physicians who know that their procedural mortality rates will be published may be less inclined to offer procedures to patients at higher risk, even though the patients could benefit from undergoing the procedure.¹⁷ Case mix issues are of particular concern for academic medical centers and for institutions and providers that serve a disproportionate share of poor and underserved patients.

Data accuracy. The financial services industry is often cited as the standard for transparency to which health care should aspire, although the scandals of recent years have demonstrated that independent audits of publicly reported financial data do not ensure accuracy. Still, much of the health data used in various public reporting schemes do not undergo even rudimentary independent review or certification. When reviews are conducted, the auditing standards are in their infancy compared with generally accepted accounting principles (GAAP) or other accounting conventions.

Sample size. Collecting performance information for a health plan with tens of thousands of members or a hospital with hundreds of admissions of a particular type each year can result in enough observations to produce stable and reliable results. Yet these aggregate measures give no indication of the performance of the physician groups or individual practitioners who actually deliver the care. For physician groups or individual physicians, however, the sample sizes are much smaller and more likely to be affected by outlier cases. Also, as the number of observations drop, concern for patient privacy increases.

Data validity. Policymakers want to ensure that quality measures accurately reflect the underlying quality or cost domain. For example, reports of infrequent medical errors may or may not indicate fundamental flaws in patient safety. Facilities that have no reported incidents may have other problems with patient safety, while those with reported incidents may have reported the exceptional or isolated cases. Similarly, reports of nursing home inspection deficiencies may not necessarily reflect the overall quality of care at the facility.

How and When Should Performance Information Be Reported?

Equally important to what performance information is reported is how, and when, it is reported. Considerable research has been conducted on how best to present performance information to consumers in ways they can understand and act on. It is clear that how and

when information is reported can significantly alter behavior. Although audiences for performance information also include providers, health plans, and policymakers, this section focuses on the needs of consumers for whom the issues of timeliness, relevance, and intelligibility are most acute.

Timeliness. Although past performance is often a good predictor of future behavior, if the data are too old, they may not accurately reflect the current status. Financial information and certain process quality measures derived from claims data are usually available from electronic administrative data sets. Even then, the results may be more than a year old by the time they are reported. Clinical information from medical records is more difficult to extract and may be much older by the time it is reported.

Relevance. The need for health care services is not always predictable, so the information a consumer may need will change considerably over time. For example, making information available on the relative cost and quality of different health plans during an open enrollment period can clearly assist consumers in choosing a health plan. However, if a consumer develops a chronic disease, he or she is likely to seek different types of information. Similarly, price information may not be the highest priority in emergency situations.

Intelligibility. With so many different audiences for health performance information, the reports need to be tailored to varying levels of health literacy, which has been defined as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.”¹⁸ Tailoring the reports so that a broad range of users can understand them remains a challenge.

What Have Been the Results of Efforts to Date?

Health services researchers have been active participants in the development of reporting tools and are now providing feedback on how efforts to improve transparency have fared. A number of lessons have been learned so far:

Public reporting adds value. Some providers and health plans have argued that merely having a feedback loop that allows hospitals, physicians, or health plans to compare their own performance to reported averages, without going public, is sufficient to improve quality. Yet numerous studies point to the positive effects of public reporting. Public reporting of comparative data on patient satisfaction enhances and reinforces quality improvement efforts already under way in hospitals.¹⁹ Making performance information public also appears to stimulate quality improvement activities in areas where performance

is reported to be low.²⁰ Another study by the same researchers indicates that making performance data public results in improvements in the clinical area cited. Surveys of consumers suggest that public reporting affects hospitals' reputations.²¹ Similarly, a study that focused on women's health indicators found that plans that restricted public access to quality-of-care information had poorer performance than those that did not.²² This still leaves open the question of who should collect and release the data: public agencies, private organizations, or public-private partnerships?

Reports must be designed carefully. An emerging body of research indicates that the way information is presented affects how it is interpreted and weighed in decisions. Some presentation approaches make it easier for users to process and integrate quality data into their choices. However, other presentation formats influence consumers' decisions in ways that undermine their self-interest.²³ A summary of research on how consumers use cost and quality data found that consumers rarely sought out the information and often did not understand it (e.g., they did not clearly understand the measures or were unsure whether low or high ratings were better). The study also found that cost and quality data have only a modest impact on consumer decision making.²⁴ A review of existing performance reports found that the design features that many of them use violate what cognitive research has found on how people process complex information.²⁵

Other research has shown that providing comparative quality information to consumers can be counterproductive unless: 1) consumers are convinced that quality problems are real and consequential, and that quality can be improved; 2) purchasers and policymakers make sure that quality reporting is standardized and universal; 3) consumers are given quality information that is relevant and easy to understand and use; 4) the dissemination of quality information is improved; and 5) health plans pay for quality improvements and providers create the information and organizational infrastructure to achieve them.²⁶

Collaboration appears to be essential. The most successful approaches to public reporting and transparency have resulted from partnerships involving the public and private sectors as well as purchasers and providers. NQF, NCQA, CMS, and many of the state reporting efforts have relied on collaborative input from various stakeholder groups. Such cooperation is necessary not only for the collection and editing of information across various provider groups and payers, but also for the designing of reporting measures and the building of an environment in which the results are deemed to be fair and accurate. If information is expected to change consumer behavior, there will be financial winners and losers, at least in the short term. While it is unlikely that complaints from the "losers" will

be eliminated, bringing all parties to the table decreases the odds of an outright revolt. Collaborative approaches also tend to be iterative or phased—that is, data elements are proposed, collected on a trial basis without public reporting, and then, after needed changes are made to the collection or reporting procedures, the results are widely released. While this kind of approach takes time, it is more likely to result in continued provider acceptance and ultimately to change behavior.

Many state and local efforts have proven successful. State and local efforts have proven successful, in part, because the scale is manageable and local sponsors can account for factors in the regional delivery system that may not be known to outsiders. As report cards and other efforts to make the health care system more accountable evolve, there should be continued support for state and local efforts.

Research and evaluation have played a critical role. The movement toward greater transparency is in its infancy, and research and concurrent evaluation have actively informed the most successful efforts. Large knowledge gaps remain. Among the areas that warrant further study are: 1) measurement methods and tools; 2) uses of quality performance data; 3) organizational and cultural factors; 4) information and informatics; and 5) evaluation of the impact of public reporting.²⁷

Automated data collection is needed. Although many of the reporting systems described above rely on administrative data sets that are generated electronically, most of the clinical information comes from incomplete billing data or from limited samples of paper medical records. When data are not routinely and unobtrusively collected as part of the ongoing care process, the result is an additional burden placed on providers and health plans. Individual hospitals, providers, and health plans participate in multiple reporting programs that are often poorly coordinated and command sizable resources.²⁸ Although electronic health records hold out the promise of making more detailed clinical results readily available, it may be many years before that promise is met.

What Federal Legislation Is Likely to Be Considered in the Next Congress?

A number of legislative proposals related directly to public reporting and transparency were brought before the 109th Congress. Most proposals aim to expand the requirements for public reporting in public programs. In addition, several proposals are focused on expanding the use of health information technology and creating an interoperable system for the nation. These could help to build the infrastructure needed to support public reporting and transparency efforts. This is likely to see further action in the immediate future. The proposals are summarized below.

Public information on quality and price:

- Ensure that Medicare beneficiaries are aware of the average and individual payment rates for inpatient and outpatient procedures and physician services.
- Require all hospitals to report data on the price and utilization frequency of designated services and pharmaceuticals.
- Require the Secretary of Veterans Affairs to publish report cards on quality.
- Encourage state Medicaid plans to make information about hospital charges and estimated out-of-pocket expenses available to the public.

Health information technology:

- Establish a national public–private collaborative to recommend uniform policies and standards in an effort to develop a nationwide interoperable health information infrastructure.
- Provide grants and/or loans to facilitate purchase and utilization of technology systems. Various proposals target providers in general, small practices, and regional health information organizations.
- Fund demonstration products to determine best practice in various areas related to health information technology, including information requirements of rural and frontier physicians and methods to integrate technology systems into clinical education.
- Provide incentives to physicians to write electronic prescriptions.
- Require all associated carriers to establish standardized electronic health records for individuals covered by the Federal Employees Health Benefits Program.
- Establish independent health record banks to store individual lifetime electronic health records.

Conclusion

Efforts to expand the availability of transparent quality and price information, particularly when this information is publicly reported, hold out the prospect of increasing accountability, enhancing and rewarding quality, and increasing efficiency. Although in the months and years ahead such information should be more readily accessible to all, there are substantial technical and political barriers that will need to be overcome.

Information on quality, whether for outcomes, process, or experience of care, is not routinely collected as part of the delivery of care. While electronic health record systems could help overcome this obstacle, these are still many years away from being widely implemented. Price and cost data, meanwhile, are obscured by the byzantine nature of the financing system. Even when financial and quality data are collected, there are significant challenges in making the information comparable across providers and plans and comprehensible to the various audiences, including patients and consumers.

Additional barriers are posed by providers and plans, which are naturally suspicious of the wide dissemination of performance information without adequate adjustment for severity or case mix. At the same time, patients and others are naturally concerned with the confidentiality of medical information used for the purpose of measuring quality.

Notwithstanding these challenges, the movement to greater transparency is inexorable. Although much work is being done exclusively in the private sector, government at all levels can play an important role by supporting the infrastructure for reporting (e.g., through research, evaluation, and data interoperability standards); by leading by example (e.g., through disclosure of performance data for government health programs); and by working collaboratively with regional and national efforts in the private sector.

NOTES

¹ Institute of Medicine, *To Err Is Human: Building a Safer Health System* (Washington, D.C.: National Academies Press, 1999).

² Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington, D.C.: National Academies Press, 2001).

³ S. R. Collins and K. Davis, [*Transparency in Health Care: The Time Has Come*](#), testimony before the U.S. House of Representatives, Energy and Commerce Committee, Subcommittee on Health (New York: The Commonwealth Fund, Mar. 15, 2006).

⁴ Health Care Financing Administration (HCFA), *Medicare Hospital Mortality Information: 1986, 1987, 1988*. HCFA Publication #00713 (Washington, D.C.: U.S. Department of Health and Human Services, 1989).

⁵ D. M. Berwick and D. L. Wald, “Hospital Leaders’ Opinions of the HCFA Mortality Data,” *Journal of the American Medical Association*, Jan. 12, 1990 263(2):247–49.

⁶ Although the initials remain the same, CAHPS was originally known as the Consumer Assessment of Health Plans Study. The new name reflects its expansion to surveys of patient experiences with health facilities, medical groups, and individual providers. It is a public–private initiative funded by the Agency for Healthcare Research and Quality (AHRQ).

⁷ By September 2005, about half the states had enacted legislation related to medical error reporting. See J. Rosenthal and M. Booth, *Maximizing the Use of State Adverse Event Data to Improve Patient Safety* (Portland, Maine: National Academy for State Health Policy, Oct. 2005).

⁸ V. Fuhrmans, “Insurer Reveals What Doctors Really Charge,” *Wall Street Journal*, Aug. 18, 2005.

⁹ A recent survey found 1.3 million individuals with high-deductible health plans and tax preferred accounts and another 8.5 million individuals with high-deductible plans and no such account. The total represents around 8% of the privately insured population and is virtually unchanged from 2005. See P. Fronstin and S. R. Collins, [*The 2nd Annual EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006: Early Experience With High-Deductible and Consumer-Driven Health Plans*](#) (Washington, D.C., and New York: Employee Benefit Research Institute and The Commonwealth Fund, Dec. 2006).

¹⁰ Executive Order 13410: Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs, Aug. 22, 2006. Appeared in the *Federal Register*, Aug. 28, 2006 71(166):51087–91.

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