Improving the Process Through Which Health Plans and Providers Exchange Performance-Related Mammography Data

Gerry Fairbrother, James Luciano, and Heidi L. Park

ABSTRACT *The ability of health plans to bring about quality improvement is limited by the fact that physician networks are highly differentiated, with physician groups participating in many plans and plans contracting with many physician groups. The primary purpose of our study was to investigate the problems in the current system of quality monitoring by managed-care organizations (MCOs) at a large integrated health care delivery system (Montefiore Medical Center) and to develop ways of addressing these problems through collaboration among MCOs. The project began by mapping the current system for collecting, reporting, and using performance data to improve performance, using breast cancer screening as an example. We found that neither health plans nor providers were satisfied with the current system. From the perspective of the health plans, the current quality monitoring was costly and, more important, was not yielding appreciable increases in screening rates. From the providers' perspective, multiple health plan requests for chart pulls and other data collection activities cost them substantial amounts of time and money and generated multiple mailings of educational materials and reports, but rarely supplied meaningful information about their performance. From the perspective of the hospital, the current procedure of reporting from MCO to provider or center bypassed the institution's own quality monitoring and management structure and thus limited the institution's ability to assist in quality improvement. This study clearly showed the importance of collaboration among plans at a given provider site. Specifically, it pointed to the need for provider-oriented reporting of data, rather than plan-oriented reporting, to give physicians numbers that they believe. It also showed the need to engage the institution's own quality-management system to assist in bringing about improvements.*

KEYWORDS *Managed care, Performance measurement, Quality improvement.*

INTRODUCTION

Managed care has ushered in an era of increased emphasis on accountability. Healthcare quality measures have been specified, most frequently by the National Committee for Quality Assurance (NCQA),¹ and protocols for measuring performance on outcomes developed, notably through the requirements for the nation's managed-care organizations in HEDIS® (Health Plan Employer Data and Informa-

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tion Set).² Health plan performance on the HEDIS indicators has been organized into “report cards” on which performance of different plans are compared for use by consumers in choosing a health plan.^{3–5} Employers also use plan performance on quality indicators as one factor in selecting health plans for employees.⁶

However, the logic for contrasting performance of different health plans rests on an assumption that plans will have distinct provider networks. Instead, partially in response to the consumers’ desire to maintain access to their personal physician, health plans have evolved large, diverse provider networks.⁷ Providers, for their part, to keep their patient base, have enrolled in as many health plans as possible.^{4,8} The result for quality is twofold. First, health plans have reduced incentive to mount quality initiatives aimed at changing provider behavior because this could improve the performance for all patients, including those enrolled in other plans. Second, feedback from plans to providers on performance of members will pertain to some, but not all, of a provider’s patients. Thus, a provider could receive a report on performance from multiple plans at different times, covering different groups of patients. This is not likely to give the provider information on a large enough portion of the patient population to be believable or relevant in indicating whether performance needs improvement. For this reason, national leaders have called for collaboration among plans on quality improvements and for a provider focus rather than a plan-level focus.⁷

The New York City managed-care market has followed the same evolution as seen more generally and is a microcosm of the problems seen nationally. Recent research in New York City by Fairbrother et al.⁹ has pointed to the overlap and duplication of monitoring by health plans in New York City. Further, Billings¹⁰ has presented compelling data showing that, in New York City, quality varies greatly by provider on a variety of indicators and has demonstrated the importance of the provider in quality improvement. The fact that quality monitoring comes from so many different sources calls for a system that reduces overlap and duplication at the provider site and at the same time yields data useful to the provider. While some efforts in the direction of plan collaboration around provider-focused quality improvement have been made,^{11–13} there is still great need for models of such an approach.

The primary purpose of our study was to investigate the problems in the current system of quality monitoring by managed-care organizations (MCOs) at a large, integrated health care delivery system (Montefiore Medical Center) by working with the largest health plan partners of its hospital. While the ultimate goal was to develop a strategy for quality improvement, an analysis of the collecting and reporting performance data was seen as a first step to collaboration around actually improving performance. This article reports on a process through which Montefiore Medical Center and its major MCO partners—the Health Insurance Plan of New York (HIP-NY), Oxford Health Plan (Oxford), and Aetna—together investigated the problems in the current system of collecting and reporting information for one performance indicator (breast cancer screening rates for eligible women) from the perspective of the health plan and of the provider organization and identified improvements that could be achieved through greater collaboration.

STUDY DESIGN AND METHODS

This study consisted of two parts. The first part was a cross-sectional study of the process through which health plans currently collect HEDIS-related mammography

data and communicate with providers about their findings. The second part was a retrospective study that was done to establish Montefiore's breast cancer screening rates; it used a methodology that includes information extracted from electronic databases not typically accessed by plans.

Description of the Provider Organization and Participating Managed-Care Plans

The project setting was Montefiore Medical Center. Montefiore is an integrated delivery system that includes two adult and one pediatric tertiary care hospitals and employs approximately 800 community and hospital-based physicians who care for patients at over 30 practice sites in the Bronx and the adjoining lower Westchester County.

Approximately 38% of the patients admitted to Montefiore's acute care hospitals each year are insured by MCOs, and 44% of these patients are covered under full-risk contracts. The 120,900 full-risk patients (18,300 Medicare, 95,200 commercial, and 7,400 Medicaid) are largely cared for by about 200 Montefiore-employed primary care physicians practicing in 25 offices (or health centers) throughout the Bronx and Westchester. Of these patients, 95% are enrolled with one of three health plans, the HIP-NY, Aetna, and Oxford.

Montefiore's Contract Management Organization, LLC, is the Montefiore management services organization to which health plans have delegated responsibility for most of the non-marketing-related functions typically performed by MCOs, including medical management and claims payment. Montefiore pays claims for most HIP-NY, Oxford, and Aetna patients; Montefiore also serves as a clearinghouse for most issues pertaining to patients in these health plans. It also plays a central role in developing and implementing plans for achieving utilization and clinical incentive targets.

The Collaborative Process

Representatives of each of the three plans and key Montefiore stakeholders explicitly expressed their support for the study's objectives and agreed to make staff available for the purpose of meetings and interviews. With the help of plan medical directors and quality improvement staff conversant with the processes through which HEDIS data were collected and disseminated, individuals were identified within each health plan and at Montefiore who had the potential to provide detailed information about current practices. Health plan and Montefiore medical directors and quality improvement staff met twice and engaged in numerous discussions and fact-finding studies between formal meeting times.

At the initial meeting, multiple HEDIS measures were discussed, but breast cancer screening only was chosen for the focus of this study. Breast cancer screening was chosen for several reasons. First, despite considerable efforts to promote screening mammography, rates for all three plans have not improved in recent years¹⁴; second, all felt that the current process for obtaining HEDIS-related mammography data from charts was possibly causing plans to underestimate their true rate; third, it was hoped that by addressing providers' concerns that the information of the plans was incomplete, providers would be more inclined to comply with the requests of the plans to promote improvement in rates if rates were found to be lower than expected; fourth, it was one of the few measures for which Montefiore electronic databases could be used to identify cases not typically captured by plans.

Study at Provider Sites to Describe Data Collection and Feedback by Managed-Care Organizations

An exploratory study of performance assessment activities specifically using HEDIS measures was conducted through interviews with the administrators of 4 of Montefiore's 25 health centers with large populations of MCO patients. The purpose of this analysis was to assess the current process, to compare perspectives, and to identify issues involved with the implementation of a new collaborative model for monitoring quality.

Questions for health centers included what they contributed to the HEDIS data collection process and what feedback they received from health plans on health center/provider performance. This included the time and effort involved with providing information from medical charts and what communication they received from health plans about the results from their reviews. Finally, respondents were asked for suggestions and criticisms about the current data collection process by plans.

Study at Three Managed-Care Organizations of Data Collection and Feedback to Providers

Medical directors and quality improvement managers involved in the collection and dissemination of HEDIS-related mammography information at each health plan were asked to describe how HEDIS mammography data were currently collected and how plans provided individual physicians or centers with feedback as to their rates. Each party was asked to estimate the yield and cost of the current process for obtaining information from charts and to offer suggestions and criticisms about the current HEDIS data collection process. At the second meeting, to corroborate our findings, results of these interviews were presented to representatives of each plan and the Montefiore network.

Special Study at Provider Site to Determine Accuracy of Health Plan Employer Data and Information Set Rates and Contribution of Provider Site Databases to Mammography Rate

To determine whether the current HEDIS data collection process could be made more efficient if provider site databases were used in addition to health plan claims databases, a special study was conducted using various Montefiore databases to obtain data on mammograms. Using information contained in its claims and eligibility databases with 2001 HEDIS technical specifications for breast cancer screening rates,* Montefiore staff identified patients in the Montefiore network who had been members for at least 18 months (HIP-NY) or 24 months (Oxford and Aetna) and sorted these patients by line of business (Medicare, Medicaid, commercial). Then, samples of 411 were randomly drawn as prescribed in HEDIS measurement procedures. If there were fewer than 411 women in the line of business (Medicare, Medicaid, commercial), the universe was used. The Montefiore claims database was consulted first to determine how many women had claims for mammograms. Efforts were then made to establish whether any of the women not found to have received a mammogram could be identified by looking for mammogram reports in

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*According to HEDIS specifications, breast cancer screening is performed for "women ages 52–69 during the measurement year with a mammogram during the measurement year or the previous year."

Montefiore's electronic medical records and Montefiore's radiology claims. A review of the medical chart was conducted for the women who had no record of mammography in any of the electronic databases. Data in the Montefiore claims database was analogous to data that would be in a health plan's administrative databases. The data from the Montefiore databases represented the reduction in chart reviews for HEDIS data collection that would result.

RESULTS

Data Collection: Health Plan Procedures

Health plans reported that they obtained data on breast cancer screening from providers in two different ways: the first was from claims data and the second was through the HEDIS performance review process. Providers submitted a claim to the health plan each time a member received a mammogram from a participating site; health plans maintained a database on these claims. Although the primary purpose of the database was to assist in paying claims, it was also used to indicate which members had received mammograms. Data collection procedures for the HEDIS audits were essentially the same for all plans. First, the health plans developed a universe of eligible women for each line of business (Medicare, Medicaid, and commercial enrollees). Eligible women for breast cancer screening were those between the ages of 52 and 69 years who had been continuously enrolled with the plan for 2 years. Next, the health plans drew a sample of 411 women from the universe in each line of business. Third, health plans looked in their own administrative claims databases to determine which of the sampled women had a claim indicating they had received a mammogram. Finally, health plans looked in medical charts for the women in the HEDIS sample for whom there was no claim. All health plans generated lists of members from this sample for whom they had no record of a claim and sent these lists to provider organizations so that charts could be pulled for examination. Health plans sent representatives to the provider organizations to review charts. The cycle for HEDIS reporting began shortly after the end of the calendar year. Eligibility determination, sample selection, and examination of health plan databases occurred in the first 3 months after the close of the reporting year. Providers were sent lists of members for chart pulls around April.

All plans reported that manually reviewing charts was a time-consuming and expensive process. It was estimated by one health plan that one chart review costs the plan \$50 per chart. All health plans reported readiness to explore a process for data exchange that made greater use of databases at Montefiore, such as the electronic medical record, if these could reduce the need for chart reviews.

Data Collection: Provider's Perspective

The Montefiore health centers received requests for chart pulls from all plans at about the same time, usually around April. Table 1 shows what the combined requests looked like from the provider point of view. The four Montefiore health centers in our study received requests for chart pulls from all plans ranging from 6 to 20 times. Each request was for varying numbers of charts, from as few as 6 to as many as 400 per request, with 108 the median number of charts per request. Requests came to the health center administrators or (less frequently) to the physicians themselves.

The health center administrator at the four Montefiore centers reported that

TABLE 1. Data collection for performance measurement

Health center	Requests for reviews from all plans (per year)	Number of charts pulled (per request)	Purpose
Williamsbridge Medical Group	6–8	15	HEDIS
Bronx East HIP Center	15–20	400	HEDIS; HIP quality management
Grand Concourse HIP Center	10–12	200	HEDIS
Co-op City Medical Group	6	6	HEDIS

HEDIS, Health Plan Employer Data and Information Set; HIP, Health Insurance Plan.

charts were reviewed as part of the HEDIS audit, and they were less frequently requested for internal plan-specific quality-management purposes as well. However, they were not always certain about what performance indicator was being looked for in the chart. Center administrators also complained that the requests from health plans were not well spaced, such that each center was faced with responding to requests from multiple plans in about the same time frame, which was usually around the month of April. Further, administrators complained that they were notified only a couple of weeks in advance and were faced with pulling a large number of charts for several plans at the same time with very little warning. Not surprisingly, the Montefiore center administrators viewed the requests for data from health plans for performance measurement as burdensome, duplicative, and costly in term of staff time.

With respect to cost, administrators from all four centers indicated that staff were diverted from other duties to perform these tasks that require additional time. The magnitude of this burden varied with the number of providers at the center and the number of plans with which their providers contracted, which influenced the number of chart requests (Table 1). This burden ranged from 312 hours of staff time at a high-volume center to only a few hours at a center with low-volume requests.

Reporting Results: Health Plans' Procedures

Table 2 shows data on breast cancer screening data reported back to providers and provider organizations. As shown in Table 2, HEDIS results for individual provid-

TABLE 2. Performance data reported to providers by health plans

Health Plan	Breast cancer screening rates from HEDIS audits		Breast cancer screening results from claims data			
	To provider*	To institution	To individual physician	How often	To institution	To member
HIP	No	No	Yes	1 X year	No	Yes
Oxford	No	No	Yes	2 X year	No	No
Aetna	No	No	No	n.a.	No	n.a.

HEDIS Health Plan Employer Data and Information Set; HIP, Health Insurance Plan; n.a., not applicable.

*Planwide rates reported in newsletters.

ers or provider groups were not reported back to providers by any of the three health plans. Rather, planwide HEDIS rates were published in plan newsletters.

However, breast cancer screening results from claims data were reported to individual providers by two of the three health plans and, for one of these plans, to individual members as well. These two plans sent a letter to each provider listing members who were not up to date on breast cancer screening. The letter typically included other pertinent materials as well, such as guidelines for screening, and one of the plans sent information to the member indicating where to go for a mammogram. Although two of the plans sent reports to physicians showing which individual members were not up to date, none of the plans sent reports to medical leadership at Montefiore. Therefore, Montefiore provider management received no feedback on performance, despite the fact that a management structure existed and was charged with monitoring and improving performance for managed-care members.

Reporting Results: Providers' Perspective

The providers' view of the reporting from plans was negative. Reports were received on a variety of performance indicators, including breast cancer screening, from many plans several times a year. However, each of the reports contained results for only a portion of their patient population. They believed that plan data on which the reports were based were flawed and underestimated their own performance. They further believed that their own performance was better than planwide HEDIS rates. Moreover, Montefiore providers did not give these planwide HEDIS results great weight because they were aggregated across multiple physicians and practices and were not specific to them.

Communication about performance in both these cases was from health plan to provider; Montefiore's provider management structure was not informed of the performance of their physicians.

Accuracy of Health Plan Employer Data and Information Set Results and Efficiency Gained From Using Montefiore Databases

Table 3 presents the results from the special study that both examined the contribution of data in Montefiore databases to the HEDIS data collection process and served as a crosscheck on the accuracy of HEDIS data. Rates were calculated for all Montefiore patients enrolled in each participating health plan that met eligibility criteria. Breast cancer screening rates from Montefiore's claims data alone ranged from a low of 49.4% to 77.7% across the plans and lines of business, as shown in the column for mammograms in claims databases. The numbers in this column represent the mammograms detected by health plans by their own administrative data. In the normal course of conducting a HEDIS evaluation, health plans would request charts from providers for the remaining women.

For this study, Montefiore databases were also examined to see if efficiency could be gained by using existing administrative data to replace costly manual chart reviews. Using provider databases could reduce duplication in data collection by the health plans. The numbers in the column on the additional claims found in the Montefiore databases show that the additional contribution to the total rate from Montefiore databases was extremely small for Oxford (0%) and Aetna (increased rate by 2.9% for commercial products and 0.9% for Medicare), with only a slightly larger increase for HIP-NY (6.3% increased rate for commercial products and 5.6% increase for Medicare). Because of the small contribution from Montefiore

TABLE 3. Special study for measuring breast cancer screening rates using provider databases*

Health plan	Line of business	Sample size N	Mammograms in claims databases		Additional mammograms found in Montefiore databases		Additional mammograms from chart review		Total mammograms reported	
			N	%	n	%	n	%	n	%
HIP†	Commercial	411	203	49.4	26	6.3	8	1.9	237	57.7
	Medicare	411	272	66.2	23	5.6	15	3.6	310	75.4
Oxford	Medicare	104	62	59.6	0	0.0	2	1.9	64	61.5
Aetna	Commercial	411	264	64.2	12	2.9	16	3.9	292	71.0
	Medicare	112	87	77.7	1	0.9	2	1.8	90	80.4

HIP, Health Insurance Plan.

*Eligible sample: Women aged 52–69 years; mammogram detected in calendar years 2000 or 2001; HIP, Oxford, and Aetna members continuously enrolled at Montefiore from January 1, 2000, to December 31, 2001.

†No claims data were available for HIP members between January 1, 2000 and July 1, 2000, because HIP centers were not contracted with Montefiore before July 2000. Chart reviews that detected a mammogram before July 1, 2000, were added to claims databases, and mammograms detected by chart review for January 1, 2000, to June 30, 2000, were estimated as 0.25 of the total number detected by chart review.

databases, the number of chart reviews that was necessary was not decreased substantially. The further increase in rates from chart reviews was also small.

Thus, despite concerns by physicians that health plan databases underestimate true screening rates, it appears that, even after adding data from Montefiore databases and chart reviews, mammography screening rates were still mediocre and not as high as physicians perceived. A collaborative chart review process between health plans and providers would, however, reduce the burden on the providers by giving them more notice and coordinating the timing of audits.

Interestingly, the fact that the rates did increase, even slightly, indicates that physicians are not submitting claims for at least some of the mammograms performed. While the addition of these mammograms that are performed but not billed would not raise the mammography screening rates substantially, it still represents underbilling and lost revenue.

DISCUSSION

This investigation exposed flaws in the current system of collecting, reporting, and using performance data to improve performance. Although this study focused on collection and reporting concerning breast cancer screening only, the problems uncovered hold more generally for other performance indicators and, indeed, pertain to the way in which health plans and providers relate on performance. Surprisingly, none of the three health plans or the providers at Montefiore Medical Center was satisfied with the current system of data collection and reporting.

From the perspective of the plans, not only was the current system of data collection and reporting for quality monitoring costly, but also it was not yielding appreciable increases in screening rates. From the providers' perspective, requests

by plans for “chart pulls” and other data collection activities cost them a substantial amount of time and money, and feedback consisted of multiple mailings of educational materials and reports, but rarely supplied meaningful information about their performance. The large volume of material from many organizations limited their ability to focus on the message from any organization.

Even more compelling than the duplication of effort in the data collection process and reporting process was the apparent disconnect between quality-monitoring activities and actual quality improvement. Rates for breast cancer screening had not significantly improved for several years. Plans reported that providers were resistant to changing their behavior and improving their screening rates because they believed that their own rates were higher than planwide rates. Our finding here is consistent with other studies, which have reported that physicians believe their own performance is better than reports show.¹⁵

Our analysis so far has shown three problems from the providers’ perspective with the quality monitoring in this undifferentiated environment: dissatisfaction with multiple requests for chart pulls, lack of information about their own performance as a whole from MCOs, and too much, often overlapping, information from multiple plans. This analysis of problems suggested several possible avenues for collaboration.

One of these involved using institutional databases at Montefiore to augment the data in the administrative databases of MCOs. If successful, this strategy would have a two-fold benefit. First, there would be fewer chart pulls because MCOs would not need to request charts for those women with a record of mammograms in the institutional databases. Second, it would permit the development of a screening rate closer to the provider level than planwide rates from the MCOs. Physicians might find this rate more believable than planwide numbers and might be motivated to take action. However, a thorough examination of administrative databases at Montefiore added few additional incidents of breast cancer screening, and chart reviews likewise turned up few additional incidents of breast cancer screening. Even after adding the additional incidences of mammography, breast cancer screening rates remained mediocre and did not differ substantially from those observed through plan performance review.

Despite the fact that this initial plan for collaboration did not have a significant effect on improving data quality or reducing the burden of chart review, this project did provide useful insights into ways that collaboration could be achieved and underscored the need for collaboration between MCOs and provider institutions for quality improvement.

One of the important insights gained by MCOs was that their methods for quality improvement, which consisted of communication between MCO and physician or center, bypassed the hierarchy at Montefiore Medical Center. Thus, there was no opportunity for the institution’s own quality-monitoring and quality-management structure to assist in correcting problems. This was an especially important finding given the fact that the providers were not motivated by the quality improvement endeavors by the multiple MCOs. Each of the three health plans involved in this investigation expressed a strong desire to involve Montefiore administration in helping to monitor and correct problems. It should be noted that despite analyses in the literature that describe the barriers to collaboration in a competitive marketplace,^{4,16} in this case, in which breast cancer screening rates for all three plans needed improvement, the gains outweighed barriers.

A second insight was that planwide rates for breast cancer screening did not

motivate providers to change behavior. They prefer, at the least, to see for Montefiore and their own or their center's rates would be better. The meaningful center- or physician-level rate would need to include patients across all or most of the plans. To develop these rates, collaboration is necessary, either by pooling data across health plans with contracts at a given institution or by having the institution develop rates from its own administrative data. Funds now used for plan-specific quality improvement (or even for chart reviews) might yield more in terms of improved performance if spent on developing provider-specific rates in collaboration with institutions.

A third insight was that the only way to reduce the burden of chart reviews done by the MCOs was to increase the rate of breast cancer screening at the institution. According to our study of breast cancer screening, rates were not low because of data reporting (as physicians had believed), but rather because the service was not being performed at high rates for members who were eligible.

We investigated one performance indicator, but the findings apply to other performance measures as well. It should be noted that mammograms performed are likely to be in administrative databases because claims are required for payment. Data reporting may be of greater concern for some of the other performance indicators, such as well care visits, for which there usually is no claim. Instead providers submit an encounter form to the MCO; the visit and services administered are noted on the form. Because the encounter form does not generate a payment, providers may be less faithful in filling out and submitting complete encounter data to the MCO. In these cases, the MCO administrative database would not have records for services performed, and chart reviews would yield a higher incidence of the service. Thus, to reduce the number of charts reviewed for encounter-based performance measures, plans and institutions would need to work collaboratively to increase reporting as well as performance of the service.

Taken together, these insights suggest the need for reporting and quality monitoring that involve the institution's own management structure, as discussed more fully in the responses to this article. A revised system with these characteristics has enormous promise in rationalizing quality monitoring in markets with undifferentiated provider networks. Collaboration around collecting and reporting data is beginning to occur in some places, most notably in California,¹² where the organization of physicians into large independent provider associations (IPAs),^{4,17} lends itself to centralized data collection and reporting. This is the first attempt in New York to develop systems of collaboration among managed-care plans to improve quality monitoring at a provider site. This attempt showed considerable promise, and future efforts should be encouraged.

ACKNOWLEDGEMENT

We gratefully acknowledge the contributions to our study by Edward Anselm, MD, and Mary Baker at HIP-NY; Richard Petrucci, MD, Christy Patterson, and Mary Jane Toomey at Oxford; Terry Golash, MD, and Judith Rice at Aetna. We also acknowledge the administrators at Montefiore health centers: Blanche Doati, Denise Taylor, Kenneth Siegel, and Camille Costa. Data collection and analysis for the special study at Montefiore were conducted by Frank Kizis, Gregg Weinberg, and Pamela McMaster.

We also appreciate the assistance of Eileen Garland, Montefiore Medical Cen-

ter, for project coordination and administrative support, and Shivani Sood, State University of New York Downstate Medical Center, for research assistance.

This research was supported by the United Hospital Fund (010253S).

NOTE

Responses to this article follow.

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Response from Provider Organization: Guidelines for Collaboration

Although managed care organizations (MCOs) and provider organizations (POs) share a common interest in increasing adherence rates, have complementary circles of influence, and often possess expertise and resources not commonly possessed by the other, it appears that relatively few formally collaborate in the development and implementation of clinical quality improvement programs. Barriers include the limited clinical performance improvement infrastructures of the POs, the need of the MCOs to implement programs in a consistent way, and access to data. Potential benefits include better outcomes, reduced costs, and improved productivity. This commentary provides a guide for collaboration drawing on the experiences gained during the initiative described in the article above by Fairbrother et al. The following describes what provider organizations can do in conjunction with multiple MCOs to plan and implement performance improvement initiatives.

A GUIDE FOR PROVIDER ORGANIZATIONS COLLABORATING WITH MULTIPLE MANAGED-CARE ORGANIZATIONS

1. *Establish accountability and channels of communication:* Since the responsibility for overseeing, planning, and implementing the clinical performance improvement programs of MCOs is often shared by individuals in multiple departments, MCOs and provider organizations interested in collaborating should begin by creating a steering committee comprised of knowledgeable and empowered individuals to represent their respective organizations and make one or two individuals responsible for sending and receiving information.

2. *Employ a FOCUS-PDCA model for performance improvement:* As described by Deming,¹ attention is initially placed on finding the problem, organizing the team, clarifying processes, and uncovering causes of problems before starting the “plan, do, check, and (re-)assess” cycle. Once the steering committee team is created and the initial problem is defined, the responsibility for clarifying current processes and uncovering the causes of problems can be delegated to work groups. The steering committee can then be used to empower the work groups, which will ultimately design and implement new initiatives and oversee the process. To facilitate the implementation of good ideas, key stakeholders on both sides must be actively involved in the early stages of planning processes.

3. *Set Reasonable Goals and Time Frames:* Establishing the channels of communication required to exchange information, resolve issues, and plan effectively is an important accomplishment in itself. Based on our experience, it may take many weeks to confirm the identity of the key stakeholders within each organization, to secure their support, and to address each of the logistical issues that may determine who can attend meetings and actively participate. Initially, it is advisable to focus on collaborating with a small number of MCOs and focus on one or two important, achievable initiatives. Since good outcome data may initially be lacking, POs may have to settle for understanding and improving certain core processes and for measuring success by tracking a leading indicator or process measure.

4. *Focus on Opportunities to Complement the Efforts of MCOs:* POs that contract with multiple health plans must become conversant with the design, con-

tent, and timing of the preventive care initiatives of MCOs. By making a limited number of individuals responsible for collecting such information, MCOs can make it easier for POs to comply with such requests. With such information in hand, POs can then focus on opportunities to complement or enhance the effectiveness of the various initiatives of the MCOs and to minimize redundancy. For example, in areas in which MCOs promote screening mammography by mailing educational materials and sending reminders, POs can focus on reinforcing the messages of the MCOs at lunchtime conferences attended by physicians and communicate directly with providers about the goals and incentives for that year's program. MCOs may also be able to supply POs with screening mammography benchmarking data specific to their organization, outcome assessment methodologies, and information about best practices.

5. Find Win-Win Opportunities to Streamline Workflows: MCOs often initiate performance improvement activities that create more work and little benefit for POs. For example, multiple MCOs may ask POs to supply information and provide access to large numbers of medical records at the same time, thus taking PO staff away from activities related to patient care. Not infrequently, because of the volume of requests, POs may be unable to comply, thus limiting the abilities of MCOs to obtain the information they need for accreditation purposes. In response, MCOs may send chart abstractors to providers' offices, costing MCOs as much as \$50 a chart, and necessitating the pulling and refiling of multiple charts by PO staff. By collaborating, POs and MCOs may find that they can minimize the number and cost of chart pulls. MCOs can help POs by coordinating the timing of their data collection and initiative efforts.

Efforts made to improve adherence with preventive care guidelines for an organization's managed-care population have the potential to have a positive impact on adherence in its other populations. These guidelines could eventually be employed to facilitate collaboration between multiple provider organizations and health plans and be adapted for programs that focus on improving clinical outcomes for high-risk patient populations.

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James M. Luciano

Response from the New York Health Plan Association, Incorporated

In the article, "Improving the Process Through Which Health Plans and Providers Exchange Performance-Related Mammography Data," Fairbrother and colleagues highlight the importance of collaboration among health plans and others within the health care system. The lack of collaboration among major stakeholders has often been identified as one of the major barriers to improvement in health care quality.

This article, however, demonstrates that successful collaboration between health plans and providers can achieve positive results.

Health plans have long been involved in projects targeted at quality improvement. A prime example is the involvement of health plans in the development and utilization of two data initiatives: HEDIS (Health Plan Employer Data and Information Set) at the national level and, at the state level, QARR (Quality Assurance Reporting Requirements). Both of these serve as tools to collect health plan data and are designed to track plan quality. Over the years, HEDIS and QARR have been the key systems for measuring and reporting quality data—for plans individually and for the managed-care industry as a whole.

In addition, a fundamental feature of managed-care health plans is the utilization of various management and monitoring systems that provide health plans with the ability to track patients and patient groups and develop programs to increase the likelihood that patients receive preventive care. Through these efforts and the development of disease-management programs, health plans are able to manage chronic conditions effectively, monitor various treatment approaches, and track the outcomes. The New York Health Plan Association (HPA)* and its member plans support the goal of comprehensive quality improvement in our health care systems. Likewise, we applaud endeavors to collaborate on quality improvement initiatives.

The collaborative model is a vital tool in the ongoing search for solutions to address quality improvement across the broad spectrum of the health care industry. When a project is of great interest and value to all participating organizations, it facilitates buy-in from each organization. This model allows responsibility for implementing the project to be shared, and participants are able to contribute in ways that do not have to be expensive in terms of time, money, or effort. As each party recognizes a “value-added” benefit of collaboration, the sum becomes greater than its individual parts.

As Fairbrother notes, duplicative requests for information from multiple sources can be frustrating and, as a result, act as a barrier to participation in quality improvement efforts. Recognizing this, over the past 2 years, HPA has focused tremendous energy and attention on expanding opportunities for health plans to improve the overall quality of health care for New Yorkers through various collaborative efforts. HPA has sought partnerships with others in hopes of working cooperatively to streamline processes and create uniformity in such ways as to foster a healthier New York.

The HPA Council and the New York State Department of Health Office of Managed Care organized leaders from physician and hospital organizations, the business community, consumers, and other major stakeholders to participate in discussions for an initial Quality Collaborative Project Summit. Although a chief objective of the quality collaborative is to redefine the relationships among the various groups, this objective is a means to an end, with the primary focus being the quality of care delivered to New Yorkers. The group has been working on developing a set of principles for collaboration aimed at select health improvement goals that will remove barriers while achieving overall improvements in health care quality.

The commitment of the managed-care community to quality improvement is

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*The New York Health Plan Association represents 19 fully licensed managed-care plan members, 8 prepaid health services plans, and 4 plans for managed long-term care that provide health care services to nearly 6 million New Yorkers.

well established. For nearly a decade, HPA has joined with other health and community organizations in coordinated efforts to advocate sound public policies that seek to reduce New Yorkers' use of tobacco and create a healthier environment for all in our state. More recently, HPA members across New York have endorsed a common guideline for the diagnosis and treatment of diabetes. This common approach to disease management was first developed and piloted by the Westchester County New York Diabetes Coalition, initiated by HPA in 1999. The coalition was formed around a shared goal of reducing diabetes-related morbidity and mortality through collaborative interventions among health plans, state and local public health agencies, and medical and professional societies.

Recognizing the benefits of collaboration among health plans working with providers, the New York State Department of Health recently issued a request for proposals (RFP) soliciting projects to develop innovative and collaborative approaches among health plans for quality improvement. At least nine programs will receive funding, with funds to be awarded in the fall of 2002.

While the collaborative model is an important development for the future of quality improvement, it is imperative to foresee and address early on potential problems that might arise in any collaborative activity. One already demonstrated significant barrier to collaborative partnerships has been difficulty in aggregating information and data. This is due to the fact that organizations may have noncompatible data technologies, varying geographic coverage areas, or simply different ways of reviewing data. These types of problems are not insurmountable; however, information system modification is a costly barrier exacerbated by federal HIPAA (Health Insurance Portability and Accountability Act) compliance requirements, which include standards for privacy and confidentiality. Another identified barrier has been competition. It is important that we rethink how and where health care providers and health plans compete and where they collaborate. Competition can and must occur, but the overarching purpose of promoting health and well-being is a matter on which health plans and health care providers can collaborate.

Vital to the goal of quality improvement is the development of trust and confidence in each other and promotion of opportunities to learn from each other. The efforts of health plans and providers in pursuing collaborations—even incrementally—will build this trust and strengthen working relationships among the parties. Government can play a role by offering incentives to collaboration, such as the Health Department's Managed Care Quality grants. As stated in Fairbrother et al.'s article, we have spent years focusing on the negative. It is time that we put aside our differences and refocus on positive things that can be done together—things that will effect positive results for patients, providers, and plans alike.

Paul F. Macielak

Response from the National Committee for Quality Assurance

The recent article "Why Is There a Quality Chasm?" by Newhouse¹ provides a strong argument that one of the major factors creating the chasm is the lack of coherent information on quality. The article by Fairbrother and colleagues provides

one explanation for the lack of information, as well as a promising approach to creating better information from existing data sources. Their approach hinges on a new type of relationship between health plans or other insurers and providers; the approach is centered on the exchange of performance data.

With the spread of managed care in the 1980s and early 1990s, the concept of the accountable health plan was created primarily by Ellwood and others in the so-called Jackson Hole group.² In their model of accountable health plans, employers and other purchasers would choose between competing health plans, each with their own unique network of physicians, hospitals, and other providers. The plans would compete on quality and cost and would in turn hold their unique network of providers accountable for quality and cost. In 1990, the National Committee for Quality Assurance (NCQA) was created largely in response to demands by employers for better information about the quality of services provided by HMOs (health maintenance organizations) and by the desire of some HMOs to standardize the information being requested by employers.³ Almost from its inception, NCQA gathered information on quality both via a traditional accreditation process based on adherence to a set of standards and through the reporting of clinical performance measures in the HEDIS® (Health Plan Employer Data and Information Set) data set. Over the past decade, HEDIS has become one of the most widely used, publicly reported, health care data sets in the United States. The set now includes more than 50 measures, including CAHPS® (Consumer Assessment of Health Plans Survey), which was developed by researchers at Harvard, RAND, and others, including NCQA, and that became an integral part of NCQA accreditation in 1999.

However, the utility of HEDIS has been limited by the fact it is currently reported only at the level of the health plan. With the demise of the Clinton health plan, and the subsequent decline of staff and group model plans, the hope of unique networks and a "top-down" health-plan-driven accountability faded. While there is still good evidence that health plans can have an important positive impact on quality,⁴ there is equal (if not more) attention now being given to enhancing accountability at the provider level.⁵ As noted above, the approach suggested in the current article by Fairbrother et al. provides one possible avenue for creating a dual accountability, with a major role for health plans being to supply information on which providers could build quality improvement activities. While removing barriers that impede and creating rewards to encourage provider quality improvement efforts are also likely to be critical, information on quality is the crucial foundation for both quality improvement efforts and for health plan or employer efforts to encourage such activity. The major problems associated with their suggested approach include the cost of pooling data from multiple sources, the need for health plan cooperation, security and privacy issues, the need for a trusted source of information, and technical problems of aggregating and reporting data at the individual or small group level.

NCQA is currently involved to varying degrees and with different partners in a number of efforts in different regions of the country; these efforts are designed to create information linkages between physician practices and multiple health plans. What follows is a very brief discussion of each of these initiatives. One of the striking features of the projects is that they are strongly influenced by a number of factors at the regional level, including the number and market position of health plans, the presence (or lack of thereof) of a history of cooperation between plans and providers, and size and influence of group practices.

In California, NCQA is one of several organizations, including the Pacific Busi-

ness Group on Health, the Independent Healthcare Association, and five large health plans, involved in an effort to pool data (electronic data from visit, laboratory, and pharmacy claims and laboratory results if possible) from health plans to create more robust data on quality at the IPA (independent physician association) or group practice level. These data will in turn be used independently (primarily to avoid antitrust issues) by the five health plans to create financial incentives linked to the level of quality achieved by the physician practice organization groups. This program is currently scheduled for implementation in January 2003. A similar effort, but limited to sharing pooled data with medical groups, is being led by the three dominant health plans in the Twin Cities area of Minnesota. The effort in Minnesota is built on the cooperation of plans and groups in creating shared guidelines and quality improvement. Uniquely among the projects, the Minnesota project focuses primarily on data obtained by chart review. In both Minnesota and California, it is expected that the IPAs and medical groups will use the data provided to improve quality both at the organizational level and at the level of individual physician or small cluster of physician office practices. Finally, NCQA is actively exploring with health plans, employers, and medical organizations similar projects in several other metropolitan areas, including New York City. Each project is centered on pooling data from multiple health plans to provide information on quality at the level of the group or individual office practice to support quality improvement efforts.

As noted, the creation of the pooled data presents a series of barriers that must be addressed. NCQA is working with other organizations, researchers, and advisory groups in attempting to address these issues. While the barriers are imposing, the approach offers substantial promise in creating the information that is critical to effective quality improvement effort and a shared accountability for quality between providers and health plans.

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L. Gregory Pawlson

Response from the New York State Department of Health’s Bureau of Quality Management and Outcomes Research

Fairbrother et al. describe a pilot project to explore the possibility of a collaborative method among three managed-care plans to collect data on one performance mea-

sure, breast cancer screening, in one integrated delivery system in New York City. We applaud their efforts and are in agreement with the goal of creating a less-burdensome process of quality measurement and oversight. The New York State Department of Health (NYSDOH) has been encouraging health plans to seek collaborative approaches to quality measurement and improvement for several years. A recently released NYSDOH request for proposals (RFP) for a \$1.6 million grant program dedicated to quality improvement requires health plans to collaborate to be eligible to receive funding.

The authors are critical of the current process of performance data collection and feedback, which in their opinion (1) results in multiple waves of data requests by each participating health plan; (2) does not accurately measure the performance of individual providers; (3) requires expensive and time-consuming chart reviews; (4) produces results that are questioned by providers for their accuracy; and (5) in this example of plans and providers, seems to bypass the administrative staff at the provider institution.

While there is no question that efficiencies in quality measurement are needed, these conclusions appear to miss more significant issues with respect to the goals and context of performance measurement for HEDIS (Health Plan Employer Data and Information Set) as required on the national level by the National Committee for Quality Assurance (NCQA) or QARR (Quality Assurance Reporting Requirements) as required by New York State, as well as managed-care quality measurement in general. First, it should be clear that HEDIS/QARR was *never* [authors' emphasis] intended to be a system of provider or institution performance measurement, and therefore it should not be surprising that it falls short in that regard. The measurement of health plans is meant to provide improved accountability for premium dollars spent by purchasers and a *population-based* [authors' emphasis] method of evaluating health care services and health outcomes. In this regard, it could be said that measurement at the health-plan level represents a long-sought connection between clinical care/medicine and public health. It is this last goal that would specifically need consideration if one is to imagine a replacement process of provider-based measurement.

In addition, much of the inefficiencies and difficulties of performance measurement could be addressed through improved administrative data capture and data use by providers and institutions. The specific measure involved in this study, breast cancer screening as measured by mammography rates, is reported by some health plans in New York using claims data only, which virtually eliminates much of the burden discussed in the article. Investment in improved data systems by providers can significantly reduce the burden and provide individual profiling data useful for improved care management by clinicians and quality improvement, the ultimate goal of measurement.

With respect to provider perceptions regarding the accuracy of performance data or the limitations of a report from a single insurer on their patients, we would offer several comments. As noted in the article, providers frequently are unaware of their own performance with respect to these indicators and are prone to overestimate performance. This report shows that perceptions of inaccuracies by providers were unfounded by the facts. It is true that small sample sizes can limit the ability to evaluate statistical significance or make firm individual comparisons to performance averages or norms. However, we would submit that feedback from a single health plan regarding a single patient who has not received a recommended service,

whether a mammogram for a woman over the age of 50 or a hemoglobin A1c test for a diabetic, is clinically relevant and should not be ignored.

With respect to the creation of a provider-based or institutionally based performance measurement process, we would offer the following comments. We believe that there has to date been no impediment from NYSDOH or from managed-care plans for this activity to occur voluntarily. Fairbrother et al. note that only 38% of patients from the integrated delivery system mentioned in the article are members of health plans. What competing, provider-based system of standardized quality measurement and public reporting exists for the other 62% of patients who receive care? The absence of a system of performance measurement for this majority of patients is an equally compelling “flaw” in our current quality measurement system that will not be addressed through reform of HEDIS/QARR collection methods.

We would welcome providers and institutions working jointly with insurers, payers, and regulators to collect, aggregate, and publicly release information on quality performance. Beyond that, we would welcome initiatives to use that information to work collaboratively to accelerate improvements in care along the lines discussed in the recently released landmark Institute of Medicine Report, “Crossing the Quality Chasm.”¹

However, in our opinion, certain requirements must be met. Similar to health plan data, the data should be available to the public, which has not been provided in the past with rare exception (cardiac surgery bypass reports, angioplasty). The process should be designed to allow aggregation of provider-level data up to the health plan level since most plans must be accountable to NCQA, NYSDOH, and purchasers for their performance. Standardized, evidence-based measures need to be employed, and validation of the data is essential for accuracy and completeness and should be no less than the current NCQA audit process. As with managed-care organizations, providers and institutions should be required to respond to performance levels that are not acceptable, and the mechanism for this accountability would need to be established. The process for data collection needs to be done annually, and in a time frame consistent with its necessary uses. Data collection must be fully compliant with requirements set forth by HIPAA (Health Insurance Portability and Accountability Act of 1996), which include provisions with respect to standardized coding processes and confidentiality/privacy. Finally, reporting is mandatory for all institutions and providers and is *not* [authors’ emphasis] optional.

Flawed as it may be, to suggest that managed-care performance measurement has not influenced provider and institution behavior is unsupported by facts. We have seen significant efforts during the time of this study outside New York City involving collaboration of health plans and providers in areas of greater managed-care penetration and influence. Since the time this study was conducted, the advancing enrollment in public managed-care programs in New York City, coupled with specific incentives directed at health plans for quality performance on HEDIS/QARR, has increased the importance and awareness of quality measurement by providers and institutions. For example, some managed-care medical directors have been working with their counterparts at institutions to develop provider profiling programs for feedback and incentives based on standardized measures in QARR. These important initiatives and their effects would be missed entirely by this study which involves two major health plans that do not participate in these programs.

Measuring the quality of care of managed-care plans in New York has proven

to be successful over time. Managed-care plans in New York have exceeded national benchmarks in nearly all performance measures in HEDIS.^{2,3} Measuring quality and requiring managed-care plans to develop root cause analyses and action plans on poor results have helped target resources for improvement. The cycle of measurement, analysis of results, intervention, and then remeasurement has led to incremental improvements in most HEDIS and QARR rates for all three payers (commercial, Medicaid, and Child Health Plus). A new system of measurement and improvement should provide no less in terms of results.

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Foster Gesten and Patrick J. Roohan

Response from the United Hospital Fund

Fairbrother and colleagues undertook an important pilot project geared toward improving data collection for quality measurement among three managed-care plans enrolling primarily employer groups (although one plan also participates in New York's public health insurance programs). We think it is valuable to explore the implications of this project for the public health insurance program beneficiaries who are enrolled in managed-care plans since virtually every state has embraced managed care as the service model for a substantial portion of its Medicaid program.

Managed-care quality reporting introduced a level of accountability and quality measurement into the health care provided to New York's Medicaid enrollees that was never available in the fee-for-service Medicaid program. The measures used in New York and the formats for public release have been modified and refined over time and represent a substantial accomplishment for state program administrators, the managed-care plans, and the providers who participate in this enterprise. This required reporting has become part of the landscape; it is an unquestioned component of doing business in New York. Managed-care plans have taken on the assignment of gathering data from their networks of providers and aggregating it into measures of plan performance. Fairbrother and colleagues ask the important question of whether this system of plan-focused quality measurement can be improved, and they explore several potential areas in which steps can be taken.

Any system of quality measurement that focuses on managed-care plans has some inherent limitations as applied to enrollees in public health insurance programs. Most performance measures require at least 12, and sometimes 24, months of continuous enrollment in the plan. A substantial share of Medicaid beneficiaries

does not have coverage for a full year, let alone stable enrollment in a managed-care plan. And, managed-care enrollment requirements do not apply to many of the frailest Medicaid enrollees. As a result, plan quality measures do not reflect the care delivered to many Medicaid beneficiaries. Since the networks of managed-care plans overlap extensively, plan performance data offer little help for consumers or purchasers in their decision making. Finally, as Fairbrother and colleagues note, data for the plan measures do not necessarily feed into provider efforts to improve quality. Indeed, some have questioned what plan performance is measuring since plans share many of the same providers and few providers have practices dominated by enrollees from a particular plan.

National leaders, as the article notes, are calling for performance measurement that focuses on providers, and many projects are under way among commercial insurance purchasers to develop key indicators of provider performance. Given the limitations of plan-focused reporting, bringing a provider focus to quality measurement is no less critical for public health insurance programs. This raises the question of how we can best obtain provider data to measure and improve quality. Should plans continue to take on this assignment? While Fairbrother and colleagues conclude that the practice can be modified, their analysis raises serious questions about whether managed-care plans are the entities best suited for this function. Alternatively, the state government could require providers to report in the same way that it now requires health plans, serving both public health insurance enrollees and commercially covered members, to supply a standard set of data annually.

As other comments on this article point out, the quality measures devised for managed-care plans were not designed to measure provider quality. The Health Plan Employer Data and Information Set (HEDIS) measures were initially devised by insurance purchasers and managed-care plans working collaboratively. In the same fashion, perhaps we need to pursue a collaborative effort among health care providers, purchasers, consumers, and plans to devise appropriate quality measures, efficient data collection practices, and effective feedback mechanisms so that we can measure and improve the quality of services delivered to all enrollees in public health insurance programs.

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