

THE STATE OF HEALTH CARE QUALITY 2008

EXECUTIVE SUMMARY

NATIONAL COMMITTEE FOR QUALITY ASSURANCE
WASHINGTON, D.C.

The State of Health Care Quality is available in its entirety at no cost at www.ncqa.org/sohc

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The American health care system is in desperate need of reform. More than 45 million Americans are uninsured. Millions more have insufficient coverage to protect them against the high cost of illness and disability. Since 2000, the cost of coverage has more than doubled, yet the quality of care patients receive is often spotty and sometimes dangerous.

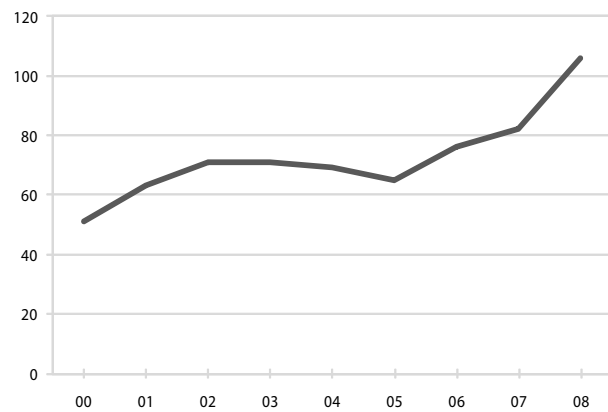
It is little surprise that a recent Commonwealth Fund survey found that 8 in 10 Americans agree that our health care system needs fundamental change.¹ Both major party candidates for President are promising reform. While the details of their plans differ substantially, each would result in a radical reformulation of the current system.

As the nation and its leaders prepare to debate the details of health care reform, it is critical that we take stock of the quality of the system we have so that we can strategically pinpoint the reforms we design. Since 1996, the National Committee for Quality Assurance (NCQA) has placed the U.S. health care system under a microscope and reported to the nation on the State of Health Care Quality. In the spring of 2008, more than 800 health plans submitted data to NCQA through the Healthcare Effectiveness Data and Information Set (HEDIS), the most widely adopted set of health care performance measures in the nation. This report presents NCQA's analysis of that data and provides a set of recommendations for our leaders to consider.

The good news: More than 100 million Americans are now enrolled in accountable health plans

The continuing efforts of health plans to measure and report on the quality of care that the patients in those plans receive has resulted in a significant milestone. For the first time, more than 100 million Americans – 106 million, to be precise – receive their care through an accountable health plan that consistently measures performance, and reports independently audited data to NCQA for public release. This represents an increase of 29 percent, or 24 million lives, in just one year. Since 2000, the number of Americans in accountable plans has more than doubled (see Figure 1).

**FIGURE 1: NUMBER OF AMERICANS
IN ACCOUNTABLE HEALTH CARE SYSTEMS**
1998 - 2007



¹ Commonwealth Fund Survey of Public Views of the U.S. Health Care System, 2008.

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As a result, today 1 in 3 Americans are enrolled in a health plan that is transparent regarding the measurement of the quality of its care and services.

This increase in accountability was driven, in large part, by the addition of nearly 100 preferred provider organizations (PPO) that reported quality data for the first time in 2008. PPOs have become the dominant plan model in the U.S., accounting for more than two-thirds of the Americans enrolled in private health plans.² The total of 240 PPO plans that reported data in 2007 represent a substantial increase from the 141 PPOs that reported data in 2006, and the 80 that reported the year before—despite a new requirement that all data be independently audited. These 240 PPOs cover a total of 41.9 million people.

All of the plans that reported this year are to be applauded for their willingness to come forward. They have demonstrated the feasibility and value of widespread quality reporting. The surge in accountability also is a tribute to the employers and regulators who have demanded greater transparency and accountability in their contracts with health plans.

In 2008, NCQA updated its Accreditation standards to require all plans to report audited HEDIS data as a condition of becoming accredited. Our experience with reporting by managed care plans has shown that such reporting drives a remarkable process of change and improvement that lifts the quality of care and improves the quality of life for patients and their families. Continued adoption of measurement, transparency and accountability by health plans and providers must be a key part of any health reform initiative.

But despite the progress reported here, more than 200 million Americans—nearly 2 in 3—remain outside this universe and know little or nothing about the quality and safety of their care. This includes the 45 million people who are uninsured and more than 150 million who have coverage either in the private sector or through such public programs as Medicare and Medicaid. This status quo clearly is unacceptable.

Quality improves in 2007, especially for members of commercial plans

The power of transparency, measurement and accountability to bring about improvement is best illustrated through one statistic: for the ninth consecutive year, health care delivered by plans that measure and report continued to improve despite rising costs and a slowing national economy.

These improvements represent real benefits for people enrolled in accountable plans. Smokers who are more consistently advised to quit are more likely to do so. People who have suffered a heart attack are likely to live longer, better lives if they and their doctors can control their blood pressure and their

² Kaiser Family Foundation/Health Research and Educational Trust (HRET) Survey of Employer Health Benefits, 2008

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cholesterol. Children who are immunized against infectious diseases stay in school and grow up to be healthier adults. And people with simple low back pain who are not subjected to unnecessary costly and possibly harmful X-rays or MRIs are more productive at work and less expensive to treat and cover. All of these improvements pay dividends not only to patients and their families but to society as a whole in our collective effort to reform health care.

Taking into account the improvements of just four measures since NCQA began measurement, as many as 205,000 lives have been saved through the more consistent delivery of care in accordance with evidence-based guidelines (*see Figure 2*).

FIGURE 2: LIVES SAVED DUE TO IMPROVEMENTS IN ACCOUNTABLE PLANS		
COMMERCIAL AND MEDICARE - 1996 - 2007		
MEASURE	LIVES SAVED	SINCE
Beta-Blocker Treatment After a Heart Attack	24,000 - 30,000	1996
Cholesterol Management	23,000 - 39,000	2000
Blood Pressure Control	76,000 - 132,000	2000
Diabetes - HbA1c Control	2,000 - 3,500	1999
TOTAL	125,000 - 205,000	

The rate of improvement was not consistent across all sectors of the health care market. Commercial plans that reported HEDIS data showed increases on 44 of 54 measures of clinical quality. 16 improvements were statistically significant—including asthma medication management, blood pressure control and postpartum care for newborns and new mothers. However, rates of appropriate antibiotic treatment for adults with bronchitis dropped sharply, as did the rate of follow-up visits for people prescribed antidepressant drugs (*see Figure 3*).

Private plans serving Medicare beneficiaries also posted gains on 24 of 45 measures of care. While most gains were relatively small, six areas of care registered statistically significant improvements. These include the persistence of beta-blocker treatment after a heart attack and proper management of antidepressants. But there were unsettling declines in screening rates for breast and colon cancer (*see Figure 3*).

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FIGURE 3: NOTABLE TRENDS IN SELECT HEDIS MEASURES			
NATIONAL AVERAGES - 2005 - 2007			
MEASURE	2005	2006	2007
COMMERCIAL			
Annual Monitoring for Patients on Persistent Medications- Total	N/A	74/3	76.6
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	33.9	28.7	25.4
Antidepressant Medication Management - Acute Phase Treatment	61.4	61.1	62.9
Antidepressant Medication Management - Contacts	20.6	20.0	18.7
Childhood Immunization Status - Pneumococcal Conjugate	N/A	72.6	83.6
Childhood Immunization Status - Combination 3	N/A	65.8	75.5
Cholesterol Management After Acute Cardiovascular Events - LDL <100 mg/dL	N/A	56.6	58.7
Controlling High Blood Pressure	68.8*	59.7	62.2
Engagement of Alcohol or Drug Dependence Treatment	14.1	13.8	15.2
Postpartum Care	81.5	79.9	82.0
MEDICARE			
Antidepressant Medication Management - Acute Phase Treatment	54.9	58.2	61.2
Antidepressant Medication Management - Continuation Phase Treatment	41.0	45.1	48.7
Breast Cancer Screening	71.6	69.5	67.3
Colorectal Cancer Screening	53.9	53.3	50.4
Harmful Drug-Disease Interactions in the Elderly - Combined Rate**	N/A	19.4	21.8

* Cannot be trended to subsequent years owing to change in measure specifications.

** A lower rate for this measure indicates better performance.

This year's data marks the second year in a row of relatively flat performance by Medicare health plans. In 2006, that performance was explained, in part, by the influx of 64 new Medicare plans. First-year plans often report lower rates of performance. This year, NCQA compared the performance of those 64 plans in 2006 and 2007 but found little improvement of the majority of measures. For details, refer to Appendix 10.

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In contrast to these steady gains, however, the quality of care provided to Medicaid beneficiaries did not show much improvement in 2008. Among the 52 measures of clinical quality collected from Medicaid plans, only 26 showed any improvement; the vast majority of these gains were small. The only area of care that improved by a statistically significant amount was childhood immunization. At the same time, there was a sharp decline in the persistent use of beta blocker drugs after a heart attack despite clear medical evidence that such relatively inexpensive treatment reduces the likelihood of another heart attack (see *Figure 4*).

FIGURE 4: NOTABLE TRENDS IN SELECT HEDIS MEASURES

MEDICAID AVERAGES - 2005 -2007

MEASURE	2005	2006	2007
Appropriate Testing for Children with Pharyngitis	52.0	56.0	59.0
Childhood Immunization Status - Combination 3	N/A	60.6	65.4
Follow-Up After Hospitalization for Mental Illness: 7 Days	39.2	39.1	42.5
Persistence of Beta-Blocker Treatment After a Heart Attack	69.8	68.1	62.0
Postpartum Care	57.0	59.1	58.5

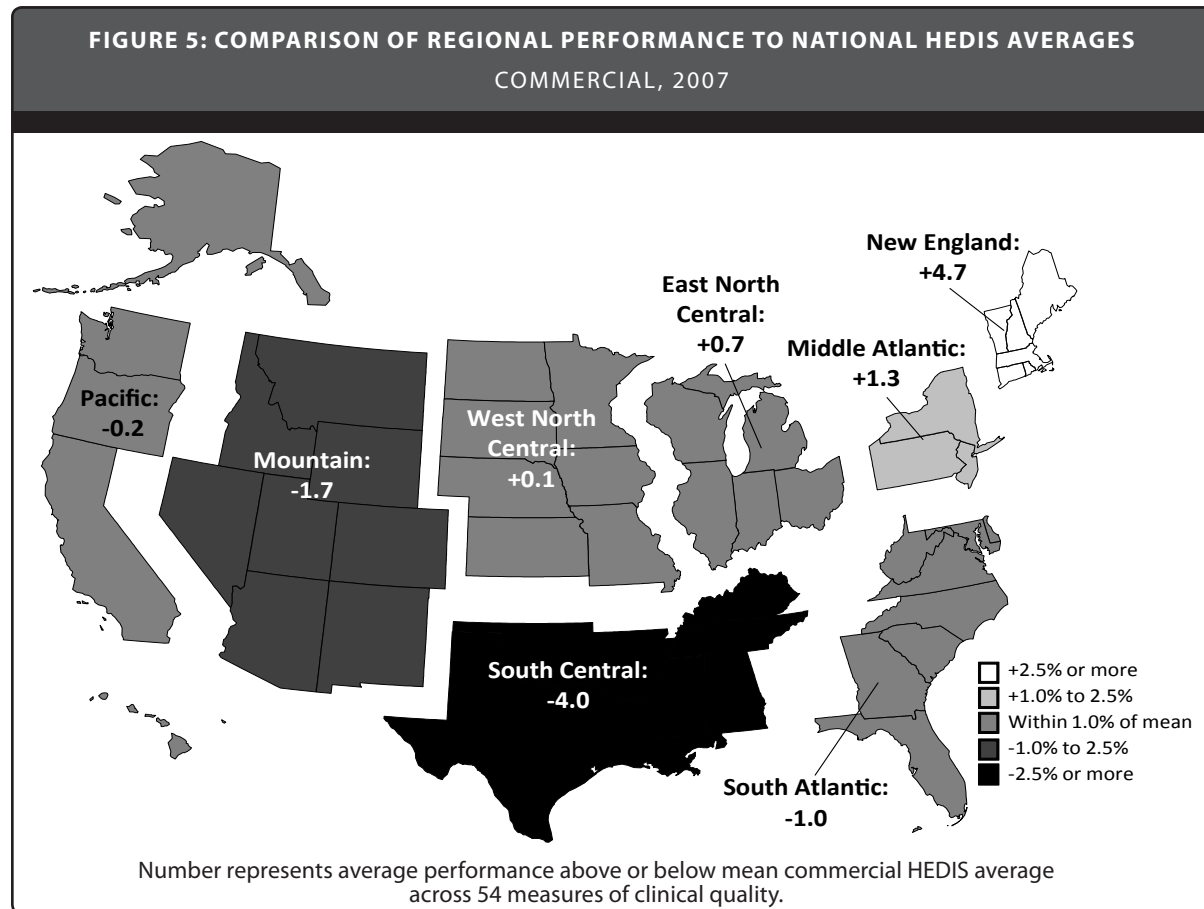
Variations in quality most apparent across regions

Even for those Americans who are in accountable health systems, the quality of care is quite uneven. A comparison of performance among plans in the eight U.S. Census regions³ of the country shows people in accountable health plans in New England and the Mid-Atlantic states tend, on average, to receive better care than people in other parts of the country.

The performance of commercial health plans in New England (Maine, New Hampshire, Vermont, Massachusetts, Connecticut and Rhode Island) exceeded the national HEDIS average by 4.7 percentage points (see *Figure 5*), while those in the Middle Atlantic (New York, New Jersey and Pennsylvania) had scores that were an average of 1.3 percentage points higher than the national mean. In sharp contrast, plans in the South Central region (Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Alabama, Tennessee and Kentucky) reported scores that averaged 4.0 points below the national HEDIS rate. Regional comparisons of Medicare and Medicaid results, available at www.ncqa.org/sohc, show similar disparities.

³ See page 20 for definitions of the U.S. Census Regions.

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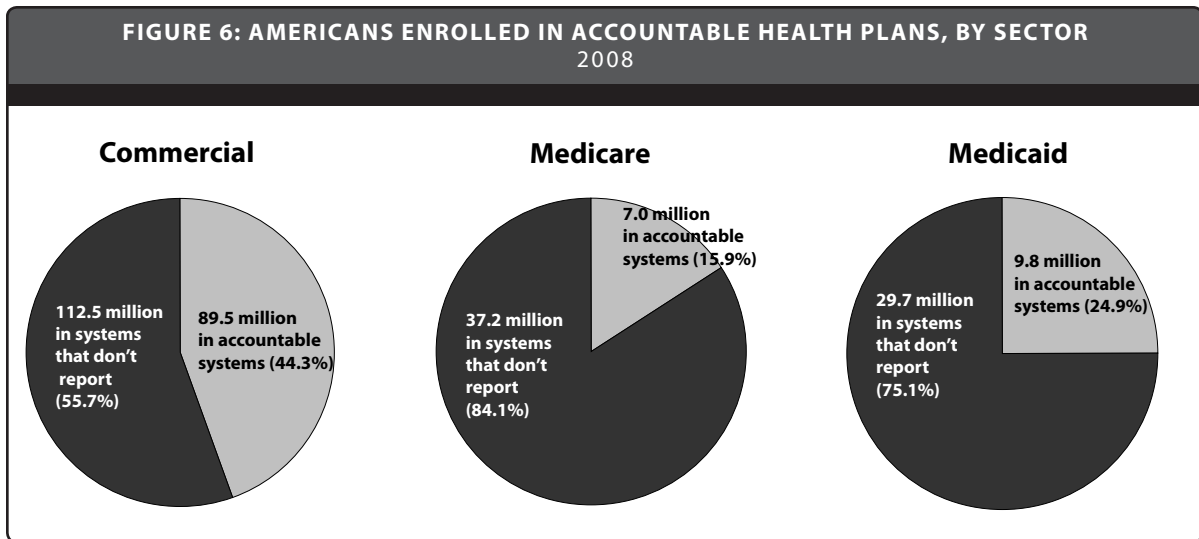
Variations in reporting, quality pervade the health care system

Americans deserve a health care system that is uniformly transparent and high performing. Regrettably, as the work pioneered by Dr. John Wennberg and his colleagues at Dartmouth Medical School has shown, that's not yet the case. As noted earlier, two thirds of Americans do not have access to information about the quality of their care.

The prevalence of quality reporting varies substantially across sectors of the health care system. Today, almost 45 percent of the estimated 202 million Americans in the commercial insurance market are enrolled in an accountable plan (see Figure 6). This is in sharp contrast with Medicare, where only 1 in 6 beneficiaries are in an accountable health care system. While most of the 8.4 million Medicare beneficiaries enrolled in Medicare Advantage plans have access to data about their plans and their care, the information for the remaining 84 percent of beneficiaries – primarily enrolled in “traditional” Medicare fee-for-service -- is spotty and incomplete.⁴

⁴ In recent years, Medicare has launched a series of efforts to measure performance in some sectors of care, including hospitals, nursing homes and home health agencies; however, these programs are mostly voluntary.

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The picture is somewhat different in Medicaid, the health program jointly operated by the federal and state governments. 64 percent of all Medicaid beneficiaries are enrolled in private health plans, but only 1 in 4 overall are in a plan that consistently measures and reports on performance.

Quality reporting also varies dramatically from state to state. Only three states have more than half their citizens in an accountable system – Massachusetts, New Jersey and Tennessee. In seven states, fewer than 1 in 10 people are enrolled in accountable systems (*see Figure 7*). Particularly disquieting is the broad swath of the nation stretching roughly from Idaho to Alabama where quality reporting—with few exceptions—is light to virtually nonexistent.

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FIGURE 8: SELECT HEDIS EFFECTIVENESS OF CARE MEASURES			
HMO vs. PPO PERFORMANCE - COMMERCIAL, 2007			
MEASURE	HMO	PPO	DIFF.
Annual Monitoring for Persistent Medications - ACE Inhibitors or ARBS	77.2	75.6	1.7
Annual Monitoring for Persistent Medications - Anticonvulsants	59.7	56.3	3.3
Annual Monitoring for Persistent Medications - Digoxin	79.7	75.7	4.0
Annual Monitoring for Persistent Medications - Diuretics	76.8	75.2	1.6
Antidepressant Medication Management - Acute Phase Treatment	62.9	63.8	(1.0)
Antidepressant Medication Management - Contacts	18.7	16.2	2.5
Antidepressant Medication Management - Continuation Phase Treatment	46.1	47.6	(1.5)
Appropriate Testing for Children with Pharyngitis	74.7	73.5	1.1
Breast Cancer Screening	69.1	64.6	4.5
Chlamydia Screening - 16-20 Years	36.4	32.4	4.0*
Chlamydia Screening - 21 - 25 Years	39.2	34.9	4.3*
DMARD Therapy for Rheumatoid Arthritis	85.3	78.9	6.4
Follow-Up After Hospitalization for Mental Illness - 30 Days	74.0	63.4	10.6*
Follow-Up After Hospitalization for Mental Illness - 7 Days	55.6	41.9	13.7*
Follow-Up for Children Prescribed ADHD Medication - Continuation	38.7	34.2	4.5*
Follow-Up for Children Prescribed ADHD Medication - Initiation	33.7	31.8	1.9
Imaging Studies for Low Back Pain	74.6	73.3	1.3
Initiation and Engagement for Alcohol or Drug Dependence Treatment - Engagement	15.2	15.2	0.0
Initiation and Engagement for Alcohol or Drug Dependence Treatment - Initiation	44.5	46.0	(1.6)
Persistence of Beta-Blocker Treatment After a Heart Attack	71.9	63.9	8.9*
Use of Appropriate Medications for Asthma	92.3	92.9	(0.6)
Use of Spirometry in Assessment and Diagnosis of COPD	35.7	33.7	2.0

Measures collected solely through claims data, * indicates statistically significant ($p < 0.05$) differences.

Interestingly, while commercial HMOs outperformed PPOs in that market, among Medicare plans, PPOs posted slightly higher HEDIS rates than their HMO counterparts (see Figure 9). The differences are quite small: an average of just over 1 percentage point.

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FIGURE 9: SELECT HEDIS EFFECTIVENESS OF CARE MEASURES

HMO vs. PPO PERFORMANCE - MEDICARE, 2007

*Measures collected solely through claims data, * indicates statistically significant (p<0.05) differences.*

MEASURE	HMO	PPO	DIFF.
Annual Monitoring for Persistent Medications - ACE Inhibitors or ARBS	84.8	87.8	(3.0)*
Annual Monitoring for Persistent Medications - Anticonvulsants	65.1	66.0	(0.9)
Annual Monitoring for Persistent Medications - Digoxin	87.9	90.4	(2.5)
Annual Monitoring for Persistent Medications - Diuretics	84.8	87.6	(2.8)
Breast Cancer Screening	67.3	64.5	2.8
DMARD Therapy for Rheumatoid Arthritis	68.7	73.5	(4.8)*
Glaucoma Screening for Older Adults	59.5	62.6	(3.1)
Initiation and Engagement for Alcohol or Drug Dependence Treatment - Engagement	4.5	6.3	(1.8)
Initiation and Engagement for Alcohol or Drug Dependence Treatment - Initiation	50.4	56.6	(6.2)*
Potentially Harmful Drug-Disease Interactions in the Elderly**: Falls + tricyclic antidepressants, antipsychotics or sleep agents	16.2	18.0	1.8
Potentially Harmful Drug-Disease Interactions in the Elderly**: Dementia + tricyclic antidepressants, anticholinergic agents	27.3	26.1	(1.2)
Potentially Harmful Drug-Disease Interactions in the Elderly**: Combination Rate	21.8	21.5	(0.3)
Use of High-Risk Medications in the Elderly - One Drug**	23.2	22.1	(1.1)
Use of High-Risk Medications in the Elderly - Two Drugs**	6.0	5.3	(0.7)
Use of Spirometry in the Assessment and Diagnosis of COPD	27.2	25.4	1.9

*Measures collected solely through claims data, * indicates statistically significant (p<0.05) differences.*

*** Lower is better for these measures; numbers in parentheses denote that PPO HEDIS rates are better.*

Variations, gaps in care exact steep toll from patients, employers

These variations in care quality – by state, region and plan type – exact a high price for patients and payers. If the entire health care system were to perform as well as the top 10 percent of plans, NCQA estimates that up to 88,900 lives could be saved each and every year, and up to \$3.7 billion in unnecessary hospital costs could be avoided (see Figure 10).

Poor quality care also leads to as many as 51.6 million avoidable sick days, the functional equivalent of removing 206,000 full-time employees from the workforce. Workers and their employers pay a high price for low-quality care. Among only five conditions, the failure to deliver evidence-based care resulted in more than \$8.5 billion in lost productivity in 2007 (See Figure 11).

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FIGURE 10: AVOIDABLE DEATHS AND MEDICAL COSTS DUE TO UNEXPLAINED VARIATIONS IN CARE

SELECT MEASURES AND CONDITIONS - 2007

MEASURE	AVOIDABLE DEATHS	AVOIDABLE HOSPITAL COSTS
Breast Cancer Screening	500 - 1,900	\$212 million - \$232 million
Cervical Cancer Screening	600 - 800	N/A
Cholesterol Management	7,000 - 17,000	\$34 million - \$115 million
Colorectal Cancer Screening	5,000 - 9,000	N/A
Controlling High Blood Pressure	14,000 - 34,000	\$425 million - \$1.1 billion
Diabetes Care - HbA1c Control	3,000 - 12,000	\$550 million - \$1.3 billion
Osteoporosis Management	N/A	\$9.8 million - \$10.5 million
Persistent Beta-Blocker Treatment After a Heart Attack	200 - 1,600	\$2.4 million - \$14.6 million
Prenatal Care	1,000 - 1,600	N/A
Smoking Cessation	7,000 - 11,000	\$712 million - \$783 million
TOTAL	38,300 - 88,900	\$1.9 billion - \$3.5 billion

*Includes days attributable to 'presenteeism,' when sick employees report to work but illness compromises their productivity.

FIGURE 11: ESTIMATED SICK DAYS* AND LOST PRODUCTIVITY DUE TO UNEXPLAINED VARIATIONS IN CARE

U.S. WORKFORCE, 2007

MEASURE	AVOIDABLE SICK DAYS	LOST PRODUCTIVITY
Asthma	7.2 million	\$1.2 billion
Depression	13.3 million	\$2.2 billion
Diabetes	12.5 million	\$2.1 billion
Heart Disease	6.3 million	\$1.0 billion
Hypertension	12.3 million	\$2.0 billion
TOTAL	51.6 million	\$8.5 billion

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Recommendations: Quality Health Care for All Americans

This report is issued at one of the rare moments when Americans and their leaders appear ready to confront the serious problems that plague our health care system. For reform to work, it must build on what works in the current system, borrow from ideas that work in other countries and create a structure that assures access to an affordable high-performing system that is focused on value – that is, cost *and* quality – and sustainability. To achieve these admirable goals, our leaders must:

Measure, measure, measure. The fact that 1 in 3 Americans are now enrolled in accountable health plans is a significant achievement for patients, plans, providers, purchasers and policy makers. But with nearly 200 million Americans in the dark when it comes to the quality of the care they receive, there is much more work to do.

Both private and public purchasers must make measurement and reporting a condition of providing coverage. The Medicare program has made great strides in this regard, including the addition of PPO HEDIS reporting this year and a Congressional mandate for reporting by private fee-for-service plans in 2010.

The Centers for Medicare & Medicaid Services (CMS) has also embarked on an evaluation strategy for the Special Needs Plans (SNP) that serve some of our most vulnerable seniors. For the first time, 444 SNPs, serving more than 1 million beneficiaries, measured their performance against measures of plan structure and process, as well as select clinical HEDIS measures.

But the vast traditional Medicare program remains the biggest challenge. Congress has called for a study comparing the quality of care in traditional Medicare versus Medicare Advantage and a plan of action for extending measurement through Medicare. This is a very promising step.

The challenges in Medicaid are more daunting. As a decentralized program, decisions about quality measurement and improvement are left to individual states. As this report shows, that has resulted in an extraordinarily uneven quality terrain. The outlines of an answer appeared in bipartisan legislation introduced in the 110th Congress that would invest in measure development and create incentives for states to report a core set of HEDIS measures that would allow state to state comparisons and national benchmarks for improvement. Enactment of this legislation in early 2009 should be a top priority for the next President and Congress.

Address and reduce variations in care and costs. Americans deserve a health care system that performs at a uniformly high level. However, as this report shows, that is not always the case. The delivery of care rooted in medical evidence varies – in some cases, dramatically – across different

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regions of the country, types of health plans and by whom is the primary purchaser. Some of these variations, to be sure, stem in part from factors outside the reach of the health care system, such as demographics and individual behavior. But many other wide variations in basic care are too big to attribute to external influences.

We must set goals for improvement and work to meet them. When implementing health care quality reforms, the new Administration should set regional targets for both quality and efficiency – and tie payments to both plans and physicians to achieving those goals.

Comparing the effectiveness of various treatments to determine what courses of care provide the most value for our limited health care resources can help point the way to a higher-performing system. But such research demands a more strategic approach than our system currently affords us. The new President should establish an independent entity to conduct and disseminate comparative effectiveness.

Reform payment systems. How we pay for health care often determines the quality of care patients receive. Too much of our current system is built on archaic models of “the more you do, the more you get.” This leads to overuse of a broad variety of health care services without improving people’s health. We must move to a system that rewards high performance and relies more heavily on payments for episodes of care, including the use of capitation payments that link costs to quality. Pay-for-performance efforts for physicians and physician groups have proven effective in aligning financial incentives and rewarding quality. Additionally, such emerging models of delivery as the patient-centered medical home hold promise for improving care coordination and a renewed emphasis on primary care. Public and private purchasers must accelerate their investment in these entities.