REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

STUDY OF VIRGINIA'S HEALTH CARE COST AND QUALITY DATA INITIATIVES PURSUANT TO HJR 513 OF 1995

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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Preface

House Joint Resolution (HJR) 513 of the 1995 Session requested the Joint Commission on Health Care to: (i) evaluate the value and utility of the methodology developed by the Virginia Health Services Cost Review Council (VHSCRC) to measure the efficiency and productivity of hospitals and nursing homes; (ii) evaluate the value and utility of the Patient Level Data Base administered by Virginia Health Information, Inc. (VHI); (iii) review the organizational structure and location of the VHSCRC and VHI; and (iv) evaluate the appropriate role of the Commonwealth versus the private sector in collecting, analyzing and publishing information on the cost and quality of health care providers and services.

Across the nation, both the public and private sectors have looked to health care cost and quality data reporting as a means of controlling costs and improving the quality of health care. In addition to the data initiatives instituted by federal and state governments to enhance the efficiency and quality of public benefit programs, providers, employers and insurers all have sought to collect and analyze data to improve their respective positions in the health care marketplace.

The objectives of these health data initiatives are to: (i) control costs by increasing competition; (ii) educate patients about the cost and quality of care so that they become more cost-conscious consumers and can select the highest quality providers and insurers; (iii) educate providers about the most cost-effective and highest quality services and procedures; and (iv) improve the quality of health care.

The public and private sectors continue to institute new data initiatives to refine health care cost and quality information. However, in recent years, some key questions regarding these initiatives have surfaced. What are the most appropriate types of health care data to be collected and what reports add the most value in the marketplace? What segment of the health care marketplace (i.e. the public or private sector) should develop and administer these initiatives? Who should finance the development and ongoing administration of these initiatives? What are the appropriate roles of the public and private sectors? The focus of the HJR 513 study was to address these questions as they relate to Virginia's current health care cost and quality data initiatives.

With respect to identifying the types of data and reports that add the most value in the marketplace, we found that most of the reports currently issued by the VHSCRC (i.e. Surveys of Hospital and Nursing Home Charges, Commercial Diversification Survey, Annual Health Care Trends, Budget Filings, and the IRS Form 990 Report) have limited value in the marketplace, and are used very little by insurers, providers, employers and consumers. These reports do not appear to be meeting the aforementioned objectives of health care cost and quality data initiatives.

The VHSCRC report which measures the efficiency and productivity of hospitals and nursing homes is viewed by several sectors of the marketplace as having significant potential value. Currently, the methodology measures only the efficiency and productivity of hospitals and nursing homes. There is substantial agreement in the marketplace that if "quality of care" measurements are added to the methodology, its value will be enhanced.

The Patient Level Data Base, which collects information on patient demographics, clinical information such as procedures and diagnoses, outcomes of treatment, and financial data, is administered by VHI through a contract with the VHSCRC. Although relatively new, the Patient Level Data Base generally is viewed as having the greatest potential value in the marketplace. Its ability to perform customized data analyses of patient treatments and outcomes is seen as having significant value for employers and others. The Patient Level Data Base reflects more of the current direction in health data analysis.

Regarding the organizational structure and location of the VHSCRC and VHI, each entity has similar data functions. Moreover, the duties and responsibilities of the 17-member VHSCRC and the 17-member VHI Board are very similar. Consequently, there appears to be some overlap and duplication in the activities of the VHSCRC and VHI. Given the limited value and utility of most of the VHSCRC reports, and the more positive assessment of the potential value of the Patient Level Data Base, a more appropriate structure may be to merge the functions of the VHSCRC into VHI. Should VHI become the only entity administering state health data initiatives, a key organizational issue that would need to be addressed is how VHI would be "linked" to state government for the purpose of promulgating regulations and receiving state funding.

The appropriate role of the Commonwealth in collecting, analyzing and disseminating health care data must be evaluated in the context of the

private sector's involvement in these health data initiatives. The private sector has expanded its efforts in this area as evidenced by the work of health care organizations such as the National Committee on Quality Assurance, the Joint Commission on the Accreditation of Health Care Organizations, business/employer groups, insurers and providers.

The most significant aspect of the Commonwealth's current role in health care data analysis (i.e. the production and dissemination of several reports on the costs of hospitals and nursing homes) appears to be having little impact in the marketplace. A more appropriate role may be to reduce the current number of reports, produce only those reports identified as adding value to the marketplace, and allow the private sector to play the primary role in health data initiatives. In this scenario, the Commonwealth would: (i) play a lesser role in collecting data and producing analytical reports on the health care marketplace; (ii) concentrate its efforts on assessing the cost and quality of its two major health programs, the state employee benefits program and the Medicaid program; and (iii) support the private sector by providing a statutory framework within which it could collect, analyze, and distribute the information it deems useful in controlling costs and improving quality.

The study offers seven policy options for restructuring the Commonwealth's health care cost and quality data initiatives. These options are not mutually exclusive.

* Option I would maintain the status quo.

* Option II would eliminate all current VHSCRC reports except the efficiency and productivity methodology; eliminate the VHSCRC and merge the efficiency and productivity methodology into VHI's functions. If VHSCRC were eliminated, VHI would have to be "linked" to another state agency. Options for "linking" VHI to state government include the Department of Medical Assistance Services, the Department of Health, the Secretary of Health and Human Resources, and the State Corporation Commission.

* Option III is the same as Option II, except that hospitals would be required to submit additional data on patient outcomes to VHI in order to compare hospitals on "quality of care" measures.

* Option IV would direct the Departments of Medical Assistance Services, and Personnel and Training to consider requiring health plans which participate in their respective programs to achieve

national accreditation and to submit plan assessments or "report cards."

* Should VHSCRC be eliminated, Option V would assign explicit responsibility to the Department of Medical Assistance Services for monitoring the financial trends, profitability and level of community support of hospitals.

* Option VI would request VHI to publish HEDIS health plan assessments voluntarily submitted by HMOs and other plans.

* Option VII would direct VHI to review the feasibility of collecting additional types of outpatient and physician data.

Our review process on this topic included an initial staff briefing which you will find in the body of this report followed by a public comment period during which time interested parties forwarded written comments to us on the report. In many cases, the public comments, which are provided at the end of this report, provided additional insight into the various topics covered in this study.

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Executive Director

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Authority for Study

House Joint Resolution (HJR) 513, which was agreed to by the 1995 Session of the General Assembly, directs the Joint Commission on Health Care to study the effectiveness and organization of the Commonwealth's health care cost and quality data initiatives. Specifically, HJR 513 requests the Joint Commission to evaluate:

* the value and utility of the efficiency and productivity methodology used by the Virginia Health Services Cost Review Council (VHSCRC), including reports prepared for consumers;

* the value and utility of the Virginia Patient Level Data Base, including reports prepared for consumers;

* the appropriate role of the Commonwealth versus the private sector as financier, researcher, administrator, and user of health care cost and quality data; and

* the appropriate organizational structure and location of the VHSCRC and the Virginia Patient Level Data Base.

Background

Across the Nation, Both the Public and Private Sectors Have Looked to Health Care Cost and Quality Data Reporting As a Means of Controlling Costs and Improving the Quality of Health Care

Private Sector Initiatives: As providers, patients, employers, insurers, and the public sector all have sought to control health care costs and improve the quality of care, the collection, analysis and dissemination of various forms of health care data have been included as part of the overall plan to make health care more affordable and effective. Health care data collection and analysis, principally claims analysis, have been undertaken by insurers for many years. More recently, managed care organizations have been developing and utilizing health plan performance assessments such as the Health Employer Data and Information Set (HEDIS) to measure their performance. Employers, who pay a large part of the nation's health care bill, more recently have undertaken a number of initiatives as a means of taking

greater control of one of its largest expenditures, namely the purchase of health insurance for active employees and retirees. Providers, too, have taken a more active role in measuring their own performance in order to survive in an increasingly competitive marketplace, and as a way of providing higher quality care.

Public Sector Initiatives: The public sector, principally the federal government and state governments, has been engaged in various health care data initiatives for many years. Due to its multiple health care roles, including purchaser (e.g. Medicaid programs and employee insurance programs), educator (e.g. teaching hospitals), public health administrator, and researcher, most state governments administer various health care data programs. According to the National Association of Health Data Organizations (NAHDO), 39 states now have legislative mandates to collect hospital level health care data. At the federal level, numerous federal agencies are involved in health care data collection, analysis and dissemination, such as the Agency for Health Care Policy and Research, the Health Care Financing Administration, and others.

Health Care Data Objectives: The objectives of these health data initiatives are: (i) to control costs by increasing competition; (ii) educate patients about the cost and quality of care so that they become more cost-conscious consumers and can select the highest quality providers and insurers; (iii) educate providers about the most cost effective and highest quality services and procedures; and (iv) improve the quality of health care.

Despite the Availability of Various Health Care Cost Data, Costs Continue to Rise; Lack of Data Regarding the Quality of Care Continues to Be a Major Concern

Despite the voluminous data that have been collected regarding the cost of health care, the cost of care has continued to rise sharply since the data have been available. (While the cost of health care has increased at a markedly slower pace the past two years, few if any experts attribute the slowing trend to the availability of health care cost data.) An equally troubling issue is the dearth of useful data regarding the quality of health care. Without knowing what quality of care has been purchased for a given cost, the value of the cost data is significantly lessened. While many efforts are underway to generate data on the quality of care, there still is a general lack of this kind of data in the marketplace.

Several Key Issues Exist Regarding Future Health Care Cost and Quality Data Initiatives

There continue to be new data initiatives being instituted by different entities in both the public and private sectors to refine health care cost information, make it more useful for various users, and develop meaningful measures of the quality of care. However, as these health care data initiatives continue, a number of key issues surface. What segment of the health care marketplace (i.e. the public sector or private sector) should be developing and conducting these initiatives? Who should be financing the development and implementation of the initiatives? What are the most appropriate types of health care data to be collected and what reports add the most value in the marketplace? What are the appropriate roles of the public and private sector?

These questions are being raised in different parts of the country as states attempt to clarify the roles and responsibilities of the public and private sectors. At the federal level, the Agency for Health Care Policy Research (AHCPR), which conducts a number of national and regional health care data initiatives, and supports other data efforts across the nation, is facing a 75% budget cut. Officials at AHCPR indicate that they are continually having to provide evidence that their data initiatives are having an impact in the marketplace and should continue to be funded.

The Health Care Financing Administration recently discontinued issuance of an annual report comparing hospitals' death rates for Medicare patients. This data initiative reportedly was stopped due to complaints from public hospitals that the death rate information did not adequately adjust for patients' severity of illness by facility.

The Pennsylvania Health Care Cost Containment Commission, which is regarded by many to be the leading state entity in health care data initiatives, had to survive attempts in the past few years to eliminate its functions due to concerns about the usefulness of their reports and the cost to the hospital industry. More recently, legislation has been introduced in the current North Carolina legislative session to eliminate the Medical Database Commission. The North Carolina legislation would transfer responsibility for publishing hospital charge information to the private North Carolina Hospital Association. The final determination regarding the future of the North Carolina commission is expected within the next few weeks.

Similar issues exist here in Virginia and form the basis for the General Assembly adopting HJR 513. This paper will analyze these issues and provide various policy options for the General Assembly to consider when

formulating the Commonwealth's approach to health care cost and quality data initiatives.

Overview of Health Care Data Reporting in Virginia

Several State Agencies Currently Collect, Analyze and Disseminate Health Care Data

In addition to the Virginia Health Services Cost Review Council (VHSCRC), a number of other state agencies, including the Departments of Health, Personnel and Training, Medical Assistance Services, and Aging, as well as the Williamson Institute at Virginia Commonwealth University/ Medical College of Virginia collect and analyze various types of health care data. While HJR 513 directs the Joint Commission to evaluate the health care data reporting by the VHSCRC and Virginia Health Information Inc. (VHI), the following paragraphs provide a brief overview of the extent of the Commonwealth's other health care data functions and initiatives.

Department of Health: As the public health agency for the Commonwealth, the Department of Health (DOH) collects a wide range of health care data. Examples of data collected by DOH include:

* health facilities (hospitals and nursing homes) licensing information,
* vital statistics regarding births, deaths, and abortions,
* a tumor registry, and
* various other health statistics.

DOH produces a number of different reports based on the information outlined above, including: the "Virginia Vital Statistics Annual Report", "Survey of Virginia Hospitals and Nursing Home Beds and Utilization - Annual Report," and others.

Department of Personnel and Training: The Department of Personnel and Training (DPT) administers the state employee health benefits program. In this capacity, it has access to detailed claims information for approximately 200,000 persons covered under the state program, including data on costs and utilization of various health care services. DPT receives computerized

analyses generated from this data but does not publish any reports for public distribution.

Department of Medical Assistance Services: The Department of Medical Assistance Services' (DMAS) primary role is administering the state's Medicaid program. In addition to possessing detailed claims information on Medicaid recipients, the agency also collects a significant amount of information from both hospitals and nursing homes through Medicaid Cost Reports and audited financial statements that are submitted by providers to the agency. One of the key uses of this data is setting the Medicaid reimbursement rates for providers.

Department for the Aging: The Department for the Aging develops, implements, and coordinates programs for older Virginians. The Department publishes various informational brochures for senior citizens. Its most comprehensive publication is the "Consumer's Guide to Long-Term Care in Virginia." This document provides a wide range of information regarding long-term care services, access to services, housing options, special care units and sources of additional information.

Williamson Institute at Virginia Commonwealth University/Medical College of Virginia: The Williamson Institute conducts a wide range of health policy studies and analyses. In its work, the Williamson Institute provides consulting services and technical analyses for state agencies as well as private sector entities. Currently, the Williamson Institute is working on projects with the Department of Medical Assistance Services, the Richmond Area Business Group on Health, Trigon BlueCross and BlueShield, and the Virginia Health Outcomes Partnership Project.

Evolution of Hospital and Nursing Home Cost Reporting in Virginia

House Joint Resolution 513 directs the Joint Commission to evaluate various aspects of Virginia's health care cost and quality data initiatives. The following paragraphs provide an overview of the evolution of hospital and nursing home cost reporting functions of the Virginia Health Services Cost Review Council (VHSCRC) and the patient level data base. Figure 1 highlights the significant developments in the evolution of hospital and nursing home cost reporting.

Figure 1

Key Dates in the Evolution of Hospital and Nursing Home Cost Reporting in Virginia

1973	Virginia Hospital Association Establishes Voluntary Rate Review Program
1978	Virginia Health Services Cost Review Council is Created
1988	Commercial Diversification Survey of Hospitals Added to VHSCRC Functions
1989	Nursing Homes Included in VHSCRC Reporting Requirements; Executive Director Became Gubernatorial Appointee; Council Increased to 15 Members
1992	VHSCRC Develops New Methodology to Measure Health Care Institutions' Efficiency and Productivity
1993	Patient Level Data Base System Established
	VHSCRC Contracted With Virginia Health Information, Inc. (VHI), a Non-Profit, Private Corporation, to Administer Patient Level Data Base System
1994	State Sponsored Outpatient Encounter Data Reported to VHI as Part of Patient Level Data Base
	Continuing Care Retirement Communities (CCRCs) Exempted from VHSCRC Reports
	First Efficiency and Productivity Methodology Report Issued by VHSCRC
	Governor's Strike Force Recommends VHSCRC Be Eliminated, and Its Functions Placed in the Department of Health
1995	Nursing Homes Exempted from VHSCRC's Commercial Diversification Survey and Budget Filing Requirements; Elimination of Duplicative Reporting Mandated; VHSCRC Required to Maximize Use of Existing Data
	VHSCRC Directed to Review Methodology for Assessing Hospital and Nursing Home Fees
	Joint Commission on Health Care Directed to Review Organization and Effectiveness of Cost and Quality Initiatives

Source: Joint Commission on Health Care Staff Analysis

Initial Hospital Cost Reporting Began in 1973

The Willey Commission was established by the General Assembly in 1971 to study the reasons for rising hospital costs. The Willey Commission recommended in 1972 that a Rate Review Board be created to address hospital costs. The General Assembly adopted a resolution requesting the Virginia Hospital Association (VHA) to develop such a board. In 1973, the VHA established the Voluntary Rate Review Program.

Citing Concerns Regarding Lack of Facility Participation in the Virginia Rate Review Program, The General Assembly Created the Virginia Health Services Cost Review Council

In 1978, lack of facility participation in VHA's voluntary rate review program prompted the General Assembly to create the Virginia Health Services Cost Review Council (VHSCRC). Legislation passed in 1978 created the VHSCRC and mandated that all hospitals report various financial and cost information. While hospitals were mandated to report data under the VHSCRC's new rate review program, hospitals' compliance with the reviews of the VHSCRC were voluntary.

VHSCRC Reporting Functions Have Been Modified Over Time

Commercial Diversification Survey and Nursing Home Reviews Were Included in VHSCRC's Functions: In 1988, House Bill 1058 was passed by the General Assembly requiring the VHSCRC to conduct a survey of hospitals' commercial diversification activities. Legislation (SB 761) passed in 1989 expanded VHSCRC's review function and reporting requirements to include nursing homes. This legislation also: (i) changed the position of Executive Director in the VHSCRC to a Gubernatorial appointee who serves at the pleasure of the Governor, and (ii) increased the number of VHSCRC members from eleven to fifteen.

1992 General Assembly Required New Methodology to Measure Efficiency and Productivity of Health Care Institutions: During 1991, VHSCRC's then current methodology for reviewing aggregate charges of facilities to determine if they were reasonably related to aggregate costs came under criticism for having little impact on institutions. The 1993 General Assembly passed SB 518 directing the VHSCRC to develop a new methodology to measure institutions' efficiency and productivity. The General Assembly also adopted Senate Joint Resolution 118 directing VHSCRC to develop a methodology that would improve the identification of the most efficient providers of high quality care in Virginia. The first report generated from the new efficiency and productivity methodology was published in December,1994.

Patient Level Data Base Was Established: In 1993, the General Assembly passed HB 2351 directing VHSCRC to develop a patient level data base. This legislation required VHSCRC to contract with a non-profit, tax-exempt health data organization to compile, store, analyze and evaluate the data. All inpatient hospitals are required to submit patient level data to this

entity. The organization currently under contract to VHSCRC to operate the patient level data base is Virginia Health Information, Inc. (VHI).

In 1994, legislation (HB 639) was passed which added state-sponsored outpatient encounter data to the Patient Level Data Base. This data includes claims data from the state employee health benefits program and claims information from Medicaid recipients.

Elimination of VHSCRC Was Recommended by Governor Allen's Strike Force and by Legislation Introduced in 1995 General Assembly Session

In October of 1994, Governor Allen's Blue Ribbon Strike Force recommended that the VHSCRC be eliminated; and that its functions be placed in the Department of Health. The Strike Force originally suggested that VHI be connected to the Department of Medical Assistance Services. However, in response to concerns expressed by the provider community, the Strike Force recommended that VHI continue to carry out its functions either as a quasi-governmental agency linked to, or an office within, the Department of Health.

Legislation (HB 2294) introduced in the 1995 General Assembly session recommended eliminating the VHSCRC and many of its functions. The legislation also recommended that the patient level data base be administered by VHI through the Department of Health. The final version of HB 2294 which passed the General Assembly exempted nursing homes from VHSCRC's commercial diversification survey and budget filing requirements; mandated elimination of duplicative reporting by health care institutions; and required VHSCRC to maximize the use of existing data.

In addition to the provisions of HB 2294, language was included in the Appropriations Act directing VHSCRC to review its methodology for assessing hospital and nursing home fees which fund their data reporting activities.

Virginia Health Services Cost Review Council: Organization, Staffing and Budget

As previously noted, the Virginia Health Services Cost Review Council (VHSCRC) was established in 1978. Chapter 26, Sections 9.1-156 et seq. of the Code of Virginia provide legislative authority for the Council to collect,

analyze and publish various health care data regarding hospitals and nursing homes.

Activities of the VHSCRC Are Directed by a 17 Member Council and Carried Out by A Separately Staffed Agency Headed By an Executive Director

Council Members Are Appointed by the Governor: The Council is comprised of 17 members, all of whom are appointed by the Governor. The composition of the Council is specified in § 9-157 of the Code as follows:

* nine members are consumers, five of whom are representatives of employers or business groups and four of whom are consumers-at-large (two of the consumer members must be experienced in financial management or accounting);

* six members are persons responsible for the administration of non-governmental health care institutions; three of whom are responsible for the administration of nursing homes and three of whom are responsible for the administration of hospitals;

* one member is an employee of a Virginia domestic insurer which underwrites accident and sickness insurance; and

* one member shall be either an employee of a commercial insurer which underwrites accident and sickness insurance or an employee of a health maintenance organization.

The Code requires that the Chairman of the Council be one of the consumer members.

VHSCRC Functions: As stated in the Code, the VHSCRC is directed to:

* undertake financial analyses and studies relating to health care institutions;

* publish and disseminate information relating to health care institutions' costs and charges;

* survey health care institutions regarding their related party transactions and commercial diversification;

* provide information concerning costs and charges to the public including information about the relationship between aggregate costs

and aggregate charges, in a form which consumers can use to compare costs and services;

* prepare and make available public summaries and compilations or other supplementary reports;

* establish and administer a methodology which measures the efficiency and productivity of health care institutions; and

* administer a patient level data base system.

A key objective of the data functions of the VHSCRC is to increase competition within the health care industry and contain health care costs.

VHSCRC Staffing and Budget: The current number of approved positions (11) is significantly less than the 21 positions authorized in the 1995 Appropriation Act. However, the current number of authorized positions has grown significantly since the VHSCRC was created in 1978.

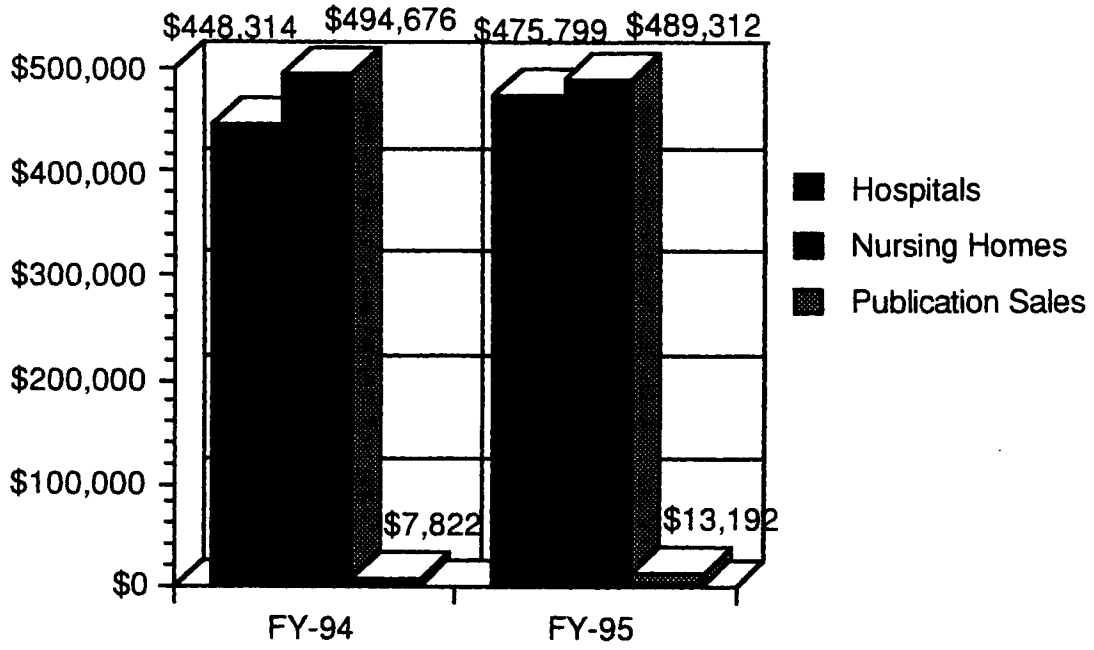
The FY 95-96 budget amount included in the 1995 Appropriation Act for VHSCRC is $1,580,391. However, the Council has approved a FY 95-96 budget of $1.2 million. Virtually all of VHSCRC's funding is supported by special revenues derived from fees assessed on nursing homes and hospitals. The fees paid by providers are based on the number of adjusted patient days at each facility. Figure 2 illustrates the fees collected from hospitals and nursing homes and the amount generated from the sales of publications in FY-94 and FY-95.

The fees paid by the institutions on Medicaid adjusted patient days are reimbursable under the Medicaid program. The fees collected by VHSCRC do not always equal the amount included in the Appropriation Act. If necessary, the VHSCRC obtains Treasury loans to fund their operations until sufficient fees are collected.

In addition to its special revenues, VHSCRC also passes through general funds to Virginia Health Information, Inc. to support the patient level data base. In the past, $200,000 had been appropriated for VHI. However, the amount contained in the 1995 Appropriation Act for FY 95-96 was reduced to $188,000.

Figure 2

Hospital and Nursing Home Fees Collected by VHSCRC: FY-94 and FY-95



Source: VHSCRC

VHSCRC Publishes Seven Reports Regarding Hospital and Nursing Home Costs and Financial Information

In accordance with the requirements of the Code, the VHSCRC publishes several annual reports on various cost and financial information regarding hospitals and nursing homes. Each of the reports published by the VHSCRC are identified below.

Annual Survey of Hospital Charges: This report has been published by the VHSCRC since 1981 and includes hospital charge information derived from survey questionnaires submitted by hospitals. The Annual Charge Report reflects the charges in place for a specific month during the year. For the 1994 report, the charges are those that were in effect during February, 1994.

The Annual Charge Survey report includes information from acute care hospitals regarding :

* ten selected hospital charges (e.g. private and semi-private rooms, intensive care unit, operating room, etc.),

* 15 commonly performed inpatient diagnoses/procedures (e.g. normal vaginal delivery, hip replacement, coronary artery bypass graft, chest pain, etc.),

* 15 commonly performed outpatient diagnoses/procedures (e.g. cataract extraction, cardiac catheterization, tonsillectomy, etc.),

* selected services for the elderly,
* third party payers with which the hospital contracts, and

* room rates, selected charges and hospital services for psychiatric, rehabilitation and ambulatory surgical hospitals.

Annual Survey of Nursing Home Charges: Similar to the hospital report, this survey publishes charge information in effect for a specific month during the year (February for the 1994 report). The report includes information on:

* room and board charges per patient day,

* skilled nursing (Medicare certified) charges,

* special nursing unit charges,

* ancillary charges (e.g. physical, occupational, and speech therapy, personal laundry and medical supplies), and
* third party payers.

Annual Report on the Efficiency and Productivity of Hospitals: The first efficiency and productivity report was issued in December, 1994. This report is designed to report relevant and comprehensive measures of hospital efficiency; and allow for benchmarking and comparison among facilities. Hospitals' efficiency is evaluated against five categories of measures: charges, costs, productivity and utilization, financial viability, and community support activities. Across the five categories, 18 specific indicators of hospital performance are assessed. Hospitals receive a score for each indicator and an overall efficiency and productivity score. Hospitals then are ranked in comparison to other hospitals in their respective region.

Annual Report on the Efficiency and Productivity of Nursing Homes: Much like the efficiency and productivity methodology for hospitals, this report uses the same five major categories of productivity and efficiency indicators to rank nursing homes. Within these categories are 13 specific indicators of nursing home performance. All of the 13 indicators are based on financial and operational data. Similar to the hospital report, nursing homes receive a score for each indicator and an overall efficiency and productivity score. Nursing homes are ranked in comparison with other nursing homes in their respective region.

Annual Report on Health Care Industry Trends, Hospitals: This report compares information regarding Virginia hospitals to similar regional and national data. The report contains information about hospital charges, costs, productivity and utilization, and financial viability. Hospital statistical information such as admissions and patient days by payer is included.

Annual Report on Health Care Industry Trends, Nursing Homes: This report compares information regarding Virginia nursing homes to similar regional and national data. The report contains information about nursing home charges, costs, productivity and utilization, and financial viability. Data on nursing home patient days by payer are also included.

Commercial Diversification Survey: This report includes information about total revenues, net profit (loss), assets and net equity in Virginia hospitals for both the institutions and their affiliates. Other information published in the report includes: a facility's business structure as either for profit or not for profit, various "types of control" (e.g. stock, member, sole proprietor, partnership ,etc.), sources of funding, and related information.

Historically, the Commercial Diversification Survey has summarized the diversification of both hospitals and nursing homes. Effective July 1, 1995, nursing homes became exempt from this reporting requirement. Since 1992, health care institutions have been required to submit financial information about all affiliates in which they have at least a 25 percent ownership interest or greater. Prior to 1992, information was reported for affiliates for which there was 50 percent or greater ownership interest.

VHSCRC Also Makes Available Other Hospital and Nursing Home Information

In addition to the published reports issued by the VHSCRC, the Council also collects other information from hospitals and nursing homes that is compiled and available for inspection upon request.

IRS Form 990 Information: As provided in § 9-160 (5), the Council collects and compiles IRS form 990 information (compensation of top executives) from health care institutions, corporations or affiliates that are organizations exempt from taxes pursuant to § 501 (c) (3) of the Internal Revenue Code. This information is not published in a printed document but is available for review at the VHSCRC.

Annual Hospital Budget Filings: Prior to July 1, 1995, both hospitals and nursing homes were required to file annual budget filings with the VHSCRC. However, pursuant to HB 2294 of the 1995 Session, only hospitals now are required to submit the filings. Like the IRS Form 990 information, the VHSCRC does not publish a printed report on this information. However, the budget filings are available for public inspection at the VHSCRC.

VHSCRC Contracted With the Williamson Institute to Develop and Refine the Efficiency and Productivity Methodology

The most recent health care data initiative of the VHSCRC is the new efficiency and productivity methodology which measures the efficiency and productivity of both hospitals and nursing homes. VHSCRC contracted with the Williamson Institute of Virginia Commonwealth University/Medical College of Virginia to develop the methodology. The Williamson Institute staff developed the methodology and produced the information included in the annual efficiency and productivity report. VHSCRC staff coordinated the printing and dissemination of the report.

Williamson Institute Is Developing "Quality" Performance Measures To Be Added to the Methodology: As will be discussed later in this issue brief, the current efficiency and productivity methodology measures only costs and financial performance of hospitals and nursing homes. VHSCRC has contracted with the Williamson Institute to develop "quality" indicators that will be incorporated into the overall methodology. The quality indicators, called the "Mark II" methodology, are scheduled to be incorporated for hospitals in the next efficiency and productivity report. The quality indicators for nursing homes are still being developed.

Virginia Patient Level Data Base System: Virginia Health Information, Inc. (VHI)

Section 9-166.1 of the Code of Virginia establishes the Virginia Patient Level Data System and assigns the VHSCRC with responsibility for administering the system. The Code identifies the specific patient level data to be reported by Virginia's inpatient hospitals. The Code also provides that the Executive Director of VHSCRC shall contract with a nonprofit, tax-exempt health data organization for the compilation, storage, analysis and evaluation of patient level data provided to the Council .

Virginia Health Information, Inc. Administers the Patient Level Data Base

The VHSCRC contracts with Virginia Health Information, Inc. (VHI) to administer the patient level data system. As required in the Code, VHI is a private, not-for-profit corporation with a board of directors representing consumers, the business community, hospitals, physicians, and insurers.

VHI Board of Directors: VHI's articles of incorporation state that the Board shall consist of 17 members as follows:

* five business representatives,
* three hospital representatives,
* three physician representatives,
* two payer representatives,
* two consumer representatives, and
* two state government representatives.

As provided in VHI's articles of incorporation, Board members are nominated by the various organizations which they represent, such as the Virginia Hospital Association, the Virginia Medical Society, the Old Dominion Medical Society, the Virginia Chamber of Commerce, the Virginia Manufacturers' Association, the Virginia Business Council, Trigon BlueCross BlueShield and the Virginia HMO Association. One state representative is nominated by the Governor and the other is nominated by the Joint Commission on Health Care. The Board elects its members from those

individuals nominated by the various organizations. VHI requires that its Chairman be a business representative.

VHI Data Collection Function: The data collected by VHI includes patient demographics, clinical information such as procedures and diagnoses, outcomes of treatment, and financial data including total charges and fees associated with specific services such as laboratory, pharmacy, and other ancillary areas. The patient level data is adjusted for differences in severity of illness, age and other factors so that data can be related to expected treatment, outcomes, and costs. Information on employer and payer are also collected. The primary function of VHI is to edit, analyze and disseminate this information. A key advantage of the patient level data system is the ability to develop customized analyses and *ad hoc* reports to meet the unique needs of various users of the data.

VHI Staffing and Budget: There are currently three full time staff employed by VHI, Inc. An Executive Director is responsible for overseeing the day-to-day activities of VHI. VHI contracts out some of its data analysis work and other administrative functions.

VHI currently receives a total of $288,000 from state sources; $188,000 from VHSCRC and $100,000 from the Department of Medical Assistance Services (DMAS). In addition to state funding, VHI generates revenue through the sale of data tapes and special projects that it performs through contracts with various entities. Currently, the state's funding represents the vast majority of VHI's budget.

Inpatient Data is Available for Analysis and Purchase; State-Sponsored Outpatient Data is Not Yet Available

Inpatient Data Is Available for Analysis by VHI and Purchase by Other Users: Patient level data for inpatient care is available by quarter beginning with the July - September quarter of 1993 and can be purchased from VHI in a variety of computer formats. The data first became available in early 1995. Private entities may purchase the data for their own analytical uses. As of June 19, 1995, 10 private entities had purchased patient level data from VHI. VHI also has made data available to several state agencies at no charge.

State-Sponsored Outpatient Data Is Not Yet Available: As previously noted, both the Department of Personnel and Training and the Department of Medical Assistance Services are required to submit outpatient data to VHI.

While initial problems with transferring the data to VHI have been resolved, the data is not yet available for analysis.

VHI Has Contracted With the Richmond Area Business Group on Health to Conduct a Study of Cesarean Section Rates

In addition to its primary mission of making patient level data available for purchase by various users, an additional activity of VHI is contracting with various entities to conduct special analyses and studies. The first such contracted study is an analysis of Cesarean Section births in the Richmond area. VHI is conducting this study for the Richmond Area Business Group on Health (RABGOH). The final report is expected to be released in the near future.

VHI also has supported various other projects with analysis and data, including a diabetes study conducted by the Department of Health, a patient origin study for the Central Virginia Health System Agency, and a cardiovascular risk reduction program.

Value/Utility of VHSCRC Health Care Data Reports and the Patient Level Data Base

One of the key directives of House Joint Resolution 513 was for the Joint Commission to assess the value and utility of the efficiency and productivity methodology and the patient level data base. In its review of these data initiatives, information also was gathered regarding the value and utility of the other data functions performed and reports issued by the VHSCRC. This section summarizes the value and utility of the VHSCRC's various reporting functions and the patient level data base system.

Interviews Were Conducted With VHSCRC and VHI Members and Staff, Industry Representatives and Others To Ascertain the Value and Utility of Reports in the Marketplace

The cost and quality of health care services are affected by a multitude of factors. Many of these factors cannot be isolated or controlled in such a way that would allow statistical measures or assessments as to whether the data functions of VHSCRC and VHI actually controlled the cost or improved the quality of health care. Inasmuch as statistical analyses would not produce reliable measures of the value or utility of the data functions, interviews were

conducted with a wide range of organizations and individuals who are involved in reporting the data, collecting and analyzing the data or using the data.

Interviews were conducted with various individuals and organizations, including:

* VHSCRC Council Members and Staff
* VHI Board Members and Staff
* Virginia Hospital Association
* Virginia Association of NonProfit Homes for the Aging
* Virginia Health Care Association
* Medical Society of Virginia,
* Virginia Association of Health Maintenance Organizations and its Member HMOs
* Several major health insurance carriers
* Virginia Chamber of Commerce, and representatives of several business and manufacturing associations
* Several major Virginia employers
* Several hospital and nursing home administrators
* Department of Personnel and Training, Department of Health, Department for the Aging, and the Department of Medical Assistance Services
* Williamson Institute Staff
* Health Insurance/benefits consulting firms
* Investment banking representative
* Virginia Health Quality Center

Interviews included questions regarding the individual's or organization's: (i) familiarity with the VHSCRC and VHI and the data available from each entity; (ii) use of the various reports/products produced by each entity; (iii) views on the kinds of health data that are of most value to them; and (iv) views regarding the appropriate role of the Commonwealth versus the private sector in health care data initiatives.

Overall, Many Potential Users are Unfamiliar with the VHSCRC Health Care Data Initiatives

With the exception of the hospital and nursing home industries which report information to VHSCRC, many potential users of the VHSCRC data are generally unfamiliar with the agency. In some instances, insurers and major employers had very little knowledge of VHSCRC. Of those interviewees who were aware of VHSCRC, very few were aware of the specific reports issued by VHSCRC. Even fewer had a working knowledge of the reports and the

data contained within the reports. Consumers (i.e. the general public) essentially have no knowledge of VHSCRC or their products.

1993 VHSCRC Study of Potential Data Users: A general finding of this study is that many potential users of VHSCRC data are unfamiliar with the VHSCRC. This finding corroborates the results of a study that VHSCRC conducted in 1993. The VHSCRC contracted with the Survey Research Laboratory at Virginia Commonwealth University to determine the effectiveness of an information campaign conducted by the Council. The Survey Research Laboratory conducted a telephone survey of employers and health insurance agencies/carriers to determine if they were aware of the agency and the reports/data that are available. Following the initial interviews, the VHSCRC sent the respondents information about the agency. Approximately 8 months after sending the information, follow-up telephone calls to the same respondents were made to evaluate the effectiveness of a public relations program to heighten organizations' awareness of the agency.

The initial telephone survey found that only 18% of the respondents were aware that a state agency published information on health care costs. Even fewer respondents identified the state agency as being the VHSCRC. Only 13% of the respondents remembered ever receiving any information or reports from the Council. However, when asked if they would use information that ranked hospitals and nursing homes, 45% of respondents stated that they would use the information.

After sending informational mailings about the Council to the respondents, the second telephone survey still found that only 49% of the respondents were aware of an agency collecting and disseminating hospital and nursing home charge information. Only 10 (7%) of the 146 "post-test" respondents identified the VHSCRC as the state agency which produces this information.

There Appears to be Little Active Use Made of VHSCRC Reports

With some exceptions, interviewees indicated that they make little active use of the reports issued by VHSCRC. Most individuals who were aware of the various VHSCRC reports indicated that while some of the information is "interesting," the data have little practical application in their respective work environments.

Consumers: The "average consumer" has little or no knowledge of the information produced by the VHSCRC. Other than articles that appear in newspapers when the reports are released, consumers are not aware of the

reports and, therefore essentially do not use them at all. Some reports (i.e. efficiency and productivity methodology) are not designed for consumers. Nonetheless, consumers make little use of the other reports.

Employers: Employers, including the Department of Personnel and Training which administers the state employee benefits program, stated that when purchasing health insurance benefits for their employees, they rely on the carriers and HMOs who insure or administer their benefits programs to develop their own provider networks. Thus, information on hospitals' charges and efficiency and productivity that is available from VHSCRC is of little practical use to them. While the information may be more useful to employers who are contracting directly with providers, none of the employers reported any "direct contracting" or any plans to do so in the near future.

Some of the larger employers which have employees in multiple states indicated that information which applies only to Virginia is of limited value to them when purchasing health care benefits for employees across the country. Smaller employers are, for the most part, unaware of the available data.

Insurers/Health Maintenance Organizations (HMOs): With rare exception, the insurers and HMOs conducting business in Virginia report that they make very little use of the data and reports issued by the VHSCRC. Insurers and HMOs indicated that they maintain their own data bases of hospital costs. Claims data bases also are used by insurers when developing benefit designs, pricing insurance policies, and negotiating hospital and nursing home contracts.

A common theme among many of the insurers and HMOs is that as long as they are able to negotiate a contract with a particular hospital that includes the price and services that make their product(s) marketable to employers and others, information regarding a hospital's charges, commercial diversification, top executives' compensation, or efficiency and productivity have little if any relevance. Insurers also noted that "charge" information is essentially meaningless to them because they do not pay charges. Their contracts with hospitals include contractual discounts off of charges.

Nursing Homes: As previously noted, the nursing home industry believes all of the VHSCRC reports are essentially useless and costly to the industry. Administrators reported reading the reports, but making no administrative decisions or taking any actions as a result of the data.

Hospitals: Hospital administrators generally noted that while the charge survey and commercial diversification survey were reviewed, they

have not made any changes in their operations based on the reports, and that the reports have little utility to them. A few mentioned that the reports are "interesting" to see what their competitors are doing, but have little practical use. Regarding the efficiency and productivity methodology, reactions were mixed. Some felt that it will have little impact on their industry. Other administrators indicated that this report is useful and "headed in the right direction." One administrator mentioned that when a new program or service is being considered at his hospital or a change in hospital policy is being considered, part of the decision process now involves the potential impact the decision will have on the hospital's efficiency and productivity ranking.

VHSCRC Receives Relatively Few Requests for Its Reports: Another indication that the VHSCRC's data functions are having a marginal impact in the marketplace is the relatively small number of requests that VHSCRC receives for its reports. Based on statistics kept by VHSCRC, 1,500 copies of the nursing home charge survey and 1,500 copies of the hospital survey were printed for 1994. Approximately 425 of each were given to providers; 675 were requested or sold. For the Annual Report, which consists of four volumes (Efficiency and Productivity - Hospitals; Efficiency and Productivity - Nursing Homes; Health Care Industry Trends - Hospitals; and Health Care Industry Trends - Nursing Homes), 1,000 copies of each volume were produced; 457 of each volume were given to providers, while 376 of each were requested or sold. Seven hundred (700) copies of the Commercial Diversification Survey were made; 396 were given to providers; 309 were requested or sold.

Affected Industries Report Few Changes Are Made at Their Facilities as a Result of the VHSCRC Reports

Hospitals and nursing home administrators reported that they have implemented few, if any, changes in their facility operations as a result of the information contained in the various VHSCRC reports. Nearly all of the nursing home administrators interviewed as part of the study indicated that the VHSCRC reports are not useful in any way, are duplicative of cost information reported to DMAS in Medicaid Cost Reports, and are a significant administrative burden on their facilities.

Hospital administrators had varying opinions on the VHSCRC reports. The charge survey generally is seen as being out-of-date and of little value due to the fact that "charges" are reported, and that few people actually pay charges. While some administrators voiced reservations about the efficiency and productivity methodology, overall, they felt this report is a positive step and in the right direction with respect to future cost and quality reporting.

The Virginia Hospital Association is very supportive of the efficiency and productivity methodology.

Value and Utility of the Reports Are Limited Because Most Persons Purchase Health Care Through Health Plans Rather Than Directly From Providers

In Virginia, approximately 86% of Virginians are covered by some form of insurance or government benefit program such as Medicaid, Medicare or CHAMPUS. Managed care, which requires that enrollees receive care from insurers' and managed care organizations' networks of hospitals and other providers, is gaining a greater market share among all of these benefit programs. Consequently, insurance programs increasingly are becoming a primary determinant of which hospitals persons go to for care. Accordingly, the value of reports which focus on the cost and quality of providers is limited to the degree that patients' choice of providers is determined by his/her insurance coverage.

VHSCRC Reports Are Being Used To Some Degree

Based on the interviews conducted as part of this study, in general, there appears to be limited practical use of the VHSCRC reports. However, the interviews did identify instances in which various reports are being used by some segments of the marketplace.

Virginia Health Systems' Agencies (HSAs): The HSAs perform reviews that are conducted as part of the Certificate of Need (CON) process. The directors of the HSAs all indicated that they regularly use the annual charge survey and the commercial diversification survey in conducting their reviews. The data also is used when conducting other types of analysis regarding the cost (charges) of health care and availability of services in their respective areas. They also indicated that they will be using the new efficiency and productivity methodology in their reviews.

Department of Medical Assistance Services (DMAS): DMAS officials indicated that the Commercial Diversification Survey is used annually when submitting information to the U.S. Health Care Financing Administration as part of their data requirements for the Medicaid program. DMAS also uses VHSCRC information on gross and net revenues to calculate statistics regarding the amount of charity care provided by hospitals. These calculations are performed as part of DMAS' administration of the Indigent Health Care Trust Fund.

Investment Banking: An investment banker interviewed during the study indicated that his firm uses the Commercial Diversification Survey, the Annual Charge Survey and the Efficiency and Productivity Methodology in performing financial analyses of hospitals' bond issues. The reports help investment bankers determine how good a risk a hospital is for individuals interested in purchasing bonds.

Richmond Area Business Group on Health (RABGOH): RABGOH has utilized the VHSCRC information in analyzing different health care issues in various markets across the state. The information has been used to: (i) assess the market share of various providers; (ii) compare charges of providers; and (iii) analyze and compare the profitability of providers.

Trigon BlueCross BlueShield (Trigon): Trigon utilizes the budget filing information in negotiating contracts with some hospitals and nursing homes. Trigon states that the value of this information is that it is "prospective" rather than historical information. Trigon indicated that it has some hospital and nursing home contracts that are "tied to" the budget information that the hospital files with the VHSCRC.

Trigon also noted that it has used the charge survey for nursing homes to assess whether charges have increased over time.

"Quality of Care" Measures are Needed to Make Reports More Valuable and Useful

One of the key issues regarding health care data reporting that is being discussed nationally is the need to include "quality of care" measures (e.g., outcomes, mortality rates, adverse affects, etc.,) with existing cost data. Without measures of the quality of care that is received in return for the costs that are paid, the value of health care data reports is limited.

Quality Indicators Are Being Added to Efficiency and Productivity Methodology: The VHSCRC has recognized the need to include quality indicators in its efficiency and productivity methodology. As previously indicated, the VHSCRC has contracted with the Williamson Institute to develop "quality of care" indicators to the efficiency and productivity methodology. For hospitals, the quality indicators are expected to include information such as mortality rates, adverse affects, discharge status, and re-admission rates. The hospital quality indicators are expected to be incorporated into the 1995 report. The quality indicators for nursing homes are still being developed; there currently is no scheduled implementation date.

VHSCRC Has Taken Steps to Eliminate Duplicative Reporting and Modify the Hospital and Nursing Home Charge Surveys

VHSCRC Study Regarding Duplicative Reporting: The VHSCRC completed a study in 1994 which found that a significant amount of the data submitted by nursing homes for the annual charge survey also was being reported to DMAS in the Medicaid Cost Reports. VHSCRC currently is working with representatives from DMAS and the Department of Health to eliminate duplicative reporting by providers.

Annual Charge Survey Being Modified: The VHSCRC also has taken steps to revise its annual charge surveys to make them more "user-friendly." VHSCRC conducted a Public Relations Workshop in March, 1995, to obtain input from various "customers" as to how the reports could be improved. Based on the results of the workshop, and in response to concerns expressed about the utility of the hospital and nursing home charge survey, the VHSCRC currently is revising the format of both charge surveys to make the reports more "consumer-friendly" and accessible.

Both the hospital and nursing home charge surveys will be modified substantially from their current form. The surveys will be printed as "consumer brochures" containing streamlined information about facilities in a specific region rather than the previous "book-like" publication which contains more complex data on a statewide basis. Separate brochures will be produced and distributed in each region of the state. Another change will be that the hospital charge report will be produced based on information reported to the patient level data base.

VHSCRC also is planning changes to the Commercial Diversification Survey to make it more "user-friendly."

Because the Patient Level Data Base Is Relatively New; It is Difficult to Evaluate Fully its Value and Utility; It is Generally Viewed as Having Significant Potential Value and Utility

The first quarters of patient level data just became available for purchase in early 1995. No written products have been issued yet. However, the various stakeholders interviewed during this study generally view the patient level data base as having the greatest potential value of any of the Commonwealth's data initiatives. One key advantage of the patient level data base is the ability to conduct customized analyses identified by data users as valuable and useful. Other advantages include: (i) the ability to analyze employee use of services for employers and compare it to other similarly

sized companies; (ii) analysis of patient demographics and clinical information such as treatment outcomes for providers; and (iii) analysis of actual use and variations in health care and outcomes by providers and health plans.

Patient Level Data on Physician Services and Outpatient Care Has Potential Value: An area of analysis that is viewed as having potential value in the marketplace is patient level information on physician/outpatient services. One of the clear trends in the health care delivery system is a move toward more and more care being provided in outpatient settings. Furthermore, whether receiving care in a hospital or an outpatient setting, physicians are involved in the delivery of both types of care. Inasmuch as more persons receive physician services than hospital services, information regarding the cost and quality of these services is seen as having potential value in the marketplace.

Efficiency and Productivity Methodology and Patient Level Data Base Are Viewed As Having Most Potential for the Future, and Represent More "State-of-the-Art" Data Initiatives

While there are those who believe that none of the current reports serve any useful purpose, in general, the efficiency and productivity methodology and the patient level data base are seen as having the greatest potential for having a positive impact on the health care marketplace. Moreover, these systems are viewed as being more "state-of-the-art" in their approach and level of analysis. As noted earlier, the addition of quality measures to the efficiency and productivity methodology will improve further the value and utility of this report.

There May Be An Intrinsic Value in Having Hospitals and Nursing Homes Report Information on the Cost and Quality of Their Services

While there may be limited practical use of several VHSCRC reports, a number of those interviewed indicated that there is an intrinsic value in having the hospital and nursing home industries report information on the cost and quality of their services. The argument here is that by having to report information that is published for public dissemination, the process alone is valuable because it forces the industries to operate their facilities with the knowledge that "the public is watching."

The critical issue is whether the intrinsic value of the process outweighs the cost and limited use of the data generated by the process.

Organizational Structure and Location of the Virginia Health Services Cost Review Council and the Patient Level Data Base System

House Joint Resolution 513 directs the Joint Commission to evaluate the organizational structure and location of the Virginia Health Services Cost Review Council (VHSCRC) and the patient level data base system, currently administered by Virginia Health Information, Inc. (VHI).

Organizational Structure: As previously noted, the VHSCRC is comprised of 17 members representing consumers, insurers, hospitals and nursing homes. It contracts with VHI to administer the patient level data base. VHI's 17 member Board of Directors includes similar types of representatives including consumer, hospital, and insurance/HMO representation.

Many of the functions of both the Council and VHI Board are similar. The primary purpose of both bodies is to provide a process of involving the key stakeholders in the development and administration of their respective health data initiatives. In an era of trying to improve the efficiency and productivity of health care services, having 34 individuals (17 member VHSCRC and 17 member VHI Board) overseeing similar types of work performed by 10-15 staff persons raises serious questions as to whether both bodies are necessary to ensure appropriate input and direction from the various stakeholders.

This overlap of activities was mentioned by a number of persons interviewed as part of this study who are familiar with the functions of both VHSCRC and VHI, including several members of VHSCRC and the VHI Board. These individuals noted that there is overlap and duplication between VHSCRC and VHI, and questioned the need to continue both entities.

The appropriate structure of VHSCRC and the patient level data base system depends in large part on what role the Commonwealth is going to play in health care data initiatives. However, inasmuch as most of the VHSCRC reports appear to have little utility or value in the marketplace and the patient level data base system reflects more of the current direction in health data analysis, a more appropriate structure may be to merge the functions of VHSCRC into VHI and have VHI administer all of the health data initiatives and products.

Placement of Nursing Home Data Function: If VHI became the single health data entity, the VHI Board would need to be consulted as to whether it believes it should become involved in data collection and analysis for long-term care services. Inasmuch as accountable health plans and integrated delivery systems are growing trends in the marketplace, it may be appropriate for VHI to assume the nursing home function. However, should it be determined that it is not appropriate for VHI to be engaged in this type of data initiative, the hospital and nursing home reporting functions possibly could be "decoupled." In this scenario, the hospital reporting functions could be consolidated under VHI and the responsibility for the nursing home efficiency and productivity methodology placed directly in DMAS. Medicaid pays for 60-70% of nursing home costs and collects other data regarding nursing home activities. Accordingly, it may be appropriate to locate the nursing home reporting function in this agency to minimize duplication of reporting.

Organizational Location: In determining the most appropriate organizational location for Virginia's health data initiatives, the critical factors to be considered are: (i) whether sufficient priority will be given to these initiatives; (ii) whether the "host" agency's other responsibilities are relevant to and consistent with those of the health data initiatives; and (iii) whether the agency's resources and staff capabilities "match" those needed to support the initiatives and maximize their potential value and utility.

Should VHI become the only entity administering the various health data initiatives, the key issue regarding organizational location is which state agency would contract with VHI and provide the "link" to state government for the promulgation of regulations and "pass-through" of state funds, assuming state funding is continued. Regardless of the organizational location chosen, it is crucial that the "host" state agency limit its involvement with VHI to only these functions and not control its day-to-day functions. The VHI Board should retain its independence and the authority and responsibility for carrying out its health data initiatives.

VHI could be "linked" with the Department of Medical Assistance Services (DMAS). DMAS may be the logical choice because of: (i) the existing cost reports and other financial information that hospitals and nursing homes submit to the agency; (ii) the financial analysis capabilities of the agency; and (iii) the related hospital financing programs under DMAS such as the Indigent Health Care Trust Fund and the State and Local Hospitalization Program. However, there likely would be concern raised, as in the past, by some providers that a conflict of interest exists with respect to an agency which collects financial data from providers and sets their reimbursement rates.

Another potential location for VHI's "link" to state government is the Department of Health (DOH). The advantage here is that DOH currently collects several other types of health data and that this additional responsibility may blend with DOH's current operations. However, the disadvantage is that DOH does not have extensive capabilities in financial analysis and reporting. Moreover, the responsibilities of DOH are far more varied than DMAS which could lead to this function not receiving the priority and prominence needed to be successful.

Another possibility would be to "link" VHI with the Secretary of Health and Human Resources. In this scenario, the state's health data initiatives would retain a prominent place in state government, and would be influenced less by the operations and priorities of another agency. The staff of the agencies within the Secretariat could provide regulatory and administrative support. The "downside" is that this type of arrangement is atypical in state government and would represent a departure from the current administrative structure.

The Role of the Commonwealth in Financing, Collecting, Analyzing and Publishing Health Care Cost and Quality Information

The appropriate role of the Commonwealth in financing, collecting, analyzing, and publishing health care cost and quality information must be assessed in terms of the Commonwealth as: (i) a purchaser of health care services; (ii) a regulator of health insurance plans and HMOs, (iii) a source of health care information and analysis for the private sector, and (iv) a catalyst for improving the affordability and quality of care in the marketplace. More importantly, the role of the Commonwealth also must be evaluated in the context of the private sector's role in developing and disseminating this type of information.

A Significant Number of Health Care Data Initiatives Are Being Pursued in the Private Sector

The role of the Commonwealth must be evaluated in the context of the private sector's role in developing and disseminating this type of information. As the private sector expands its efforts in collecting, analyzing and disseminating useful health care data, the role that the Commonwealth can or

should play is narrowed. As is evidenced in the following paragraphs, a significant number of initiatives have been implemented in various segments of the private sector.

National Committee on Quality Assurance (NCQA): NCQA assesses the quality of managed care programs through an accreditation process and a performance measurement function. The accreditation process involves an evaluation of health plans' internal quality management systems. Areas of review include: (i) quality improvement, (ii) physician credentialling, (iii) utilization management, (iv) members' rights and responsibilities, (v) preventive health services, and (vi) medical records. NCQA anticipates it will have completed reviews of over 300 plans by the end of 1995.

Attaining NCQA accreditation is becoming an important "seal of approval" for health plans as they compete to be included in employers' health benefits offerings to employees. Some employers are requiring plans bidding for inclusion in their benefit programs to have NCQA accreditation. The result has been that the marketplace is driving health plans to achieve a minimum level of performance which in turn improves the quality of care that members receive from these plans.

The performance measurement component of NCQA's activities is the "HEDIS" project. The acronym "HEDIS" stands for Health Employer Data and Information Set. The HEDIS project is a "report card" initiative of NCQA aimed at developing a set of uniform, standardized performance measures that can be used to document the quality and value of health plans, and, in time, allow for "apples to apples" comparisons among plans. In a recently completed HEDIS pilot project involving 21 health plans from across the country, plans were compared on the basis of: (i) member satisfaction, (ii) quality of care and access to care, (iii) physician networks, (iv) utilization rates, (v) membership and finance issues, and (vi) revenues and rates.

As with the accreditation process, more and more employers are looking to HEDIS and other "report card" methodologies as a means of determining which health plans offer the highest quality services at the lowest prices. Some health plans are responding by conducting these types of assessments in order to gain a competitive advantage.

Joint Commission on Accreditation of Healthcare Organizations: The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has accredited various types of health care organizations (i.e. hospitals, ambulatory care, home care, long term care and mental health care organizations) for many years. However, recently, the JCAHO has begun to

issue "performance reports" on these organizations. The performance reports include 15 performance areas (e.g. infection control, quality of care, medical records, etc.) for which the facility receives a score ranging from 0 to 100 with 100 representing a perfect score. Reports can be purchased for $30.

One possible use of this information would be for a public service or governmental entity to purchase these reports for the facilities in a given area and make them available to the public.

Richmond Area Business Group on Health HEDIS Project: An example of the private sector pursuing health data initiatives is the current HEDIS project being sponsored by the Richmond Area Business Group on Health (RABGOH). RABGOH has contracted with the Williamson Institute to assist it in working with managed care organizations in the Richmond area to submit HEDIS data for analysis and publication. The HEDIS reports will be disseminated to RABGOH members to assist them in comparing and purchasing HMO services.

Williamson Institute Activities: As discussed previously, the Williamson Institute at Virginia Commonwealth University/Medical College of Virginia developed the new efficiency and productivity methodology. Through this and other initiatives, the Williamson Institute has distinguished itself as a valuable center for health policy and data analysis. Currently, it is involved in a number of health data collection and analysis projects. The Williamson Institute is working with DMAS on a project to assess the quality of certain aspects of the Medicaid program. This project includes three major components: (i) physician practice profiling, (ii) medical record reviews, and (iii) patient satisfaction surveys.

Another major project involves patient satisfaction surveys with various Trigon BlueCross BlueShield enrollees, including state employees covered under the Key Advantage program. The institute also is doing some outcomes research with Trigon regarding certain diagnoses.

Insurance Industry Analysis and Research: As previously noted, the insurance industry maintains its own health care data bases. The industry is using these data to do cost analyses, outcomes research and quality assessments. While many of these efforts are designed to improve the competitiveness of individual plans, consumers nonetheless benefit from these types of analyses.

Consumer Reports: The most recent issue of the publication "Consumer Reports" includes a special section on rating the quality of 43

nursing home chains and religious affiliated groups representing about 4,000 nursing homes. The report provides ratings that are based on 69 federal standards relating to residents' health and well-being. Consumers can use this type of information in assessing the value and quality of nursing home services.

In addition to national publications, some localities in Virginia periodically publish information regarding health care charges and services. For example, the June, 1995 issue of the magazine "The Roanoker," contains a special section which provides information regarding the costs and services of nursing homes in the Roanoke area. The special section also lists sources of additional information regarding nursing homes. The VHSCRC reports are not mentioned as potential sources of information.

These and other similar initiatives mitigate the need for state government to necessarily be the primary source for all health care data collection, analysis and dissemination.

As a Purchaser of Health Care Services, the Commonwealth Should Maintain Sufficient Cost and Quality Information to Make Prudent and Cost-Effective Purchasing Decisions

A key consideration in determining the appropriate role of the Commonwealth in health care data collection, analysis and dissemination is the data it needs to make prudent and cost effective purchases of health insurance benefits for state employees and health care services for Medicaid recipients. Accordingly, one determinant as to whether certain data should be collected, analyzed and published by the Commonwealth is whether these programs can and will make use of the information. To the degree information is not useful to these programs, more careful scrutiny should be given to the Commonwealth's involvement in generating the data.

The Department of Personnel and Training does not use the VHSCRC reports in administering the state employee benefits program, and the Department of Medical Assistance Services makes limited use of the information.

As a Regulator of Insurance Plans and HMOs, Information is Needed to Ensure Plans Adhere to Statutory and Regulatory Requirements

In regulating health insurance companies and HMOs, the State Corporation Commission's Bureau of Insurance needs financial and other information on insurers and HMOs to ensure that they comply with the

insurance laws of the Commonwealth. The Bureau has statutory and regulatory authority to collect the information it needs in this regard. A key issue here regarding the Commonwealth's role in health care cost and quality data is whether additional information regarding the quality of services offered by insurers and HMOs, such as a "report card," is appropriate for the Commonwealth to pursue.

There is considerable activity among insurers/HMOs and the business/employer communities in developing "report cards" on managed care organizations. The market forces that employers are exerting on plans to achieve accreditation and participate in HEDIS type report cards are moving the insurance and HMO industries in this direction at a relatively swift pace. As such, it does not seem appropriate at this time for the Commonwealth to mandate health plan assessments or "report cards" as part of its role in health care cost and quality data initiatives. However, it may be appropriate to publish report card assessments voluntarily submitted by health plans.

One issue that should be given further consideration by the Commonwealth regarding health plan assessments or "report cards" is whether the state employee insurance program and the Medicaid program should require health plans which participate in these programs to be NCQA accredited and/or provide HEDIS-type information when applicable. These programs could publish this information as part of the plan descriptions that enrollees use to select their benefit plans. By doing so, enrollees would have useful information about the quality of the services offered by the plans for which they are eligible to enroll.

The Commonwealth's Role in Providing Health Care Data for the Private Sector and General Public Should Be Limited to That Information Which Is Useful and Not Available From Other Sources

While some states, such as Maryland, have taken a more regulatory approach to effecting changes in the health care marketplace, Virginia has taken more of a "market approach" to improving the cost, availability, and quality of health care services and insurance. Consistent with this market-based approach, the appropriate role of the Commonwealth with respect to health data initiatives should be to support the efforts of the private sector, and provide a statutory and regulatory framework that facilitates the development and dissemination of this information in the marketplace. To the degree that the Commonwealth represents the only means by which useful and valuable data can be collected, analyzed and disseminated, the Commonwealth should fill this need.

In short, the Commonwealth should play a supportive role in this endeavor, rather than the primary role.

Health Care Cost and Quality Data Initiatives In Other States

39 States Have Mandates to Collect Hospital-Level Data

According to the National Association of Health Data Organizations (NAHDO), there are 39 states with mandates to collect hospital level data. The data that are collected as well as the organizational structure, location and funding mechanisms vary from state to state. The following states do not have mandates to collect hospital-level data: Alabama, Alaska, Arkansas, Hawaii, Idaho, Louisiana, Michigan, Mississippi, Montana, Nebraska, and Wyoming.

A survey was sent to the 38 other states which collect hospital-level data to ascertain how their data collection programs operate. A total of 29 states responded to the survey. Figure 3 identifies those states which operate hospital level data collection activities and those states which responded to the survey.

The health data function operates as a separate agency in 11 of the states which responded to the survey. In some of these states, the separate agency or commission is "attached" or "linked" to another agency for administrative support. For example, the North Carolina health data function is a separate commission which is "administratively attached" to the Department of Insurance, and the staff are employees of the insurance department.

Structure and Operation of Other States' Health Data Initiatives

Organizational Structure: Of the 29 states which responded to the survey, 18 states have located their hospital-level health data function in an existing state agency. Most of these states (16) have placed the function in their health department. In Wisconsin, the health data function is a subunit of the Bureau of Insurance.

Figure 3

States With Mandates to Collect Hospital Level Data; States Responding to Joint Commission on Health Care Survey

Arizona	California	Colorado*
Connecticut*	Delaware*	Florida*
Georgia	Illinois*	Indiana*
Iowa*	Kansas*	Kentucky*
Maine*	Maryland	Massachusetts*
Minnesota	Missouri*	Nevada*
New Hampshire*	New Jersey*	New Mexico*
New York*	North Carolina*	North Dakota*
Ohio	Oklahoma*	Oregon
Pennsylvania*	Rhode Island	South Carolina
South Dakota*	Tennessee	Texas*
Utah*	Vermont*	Washington*
West Virginia*	Wisconsin*	

* States which responded to Survey

Source: National Association of Health Data Organizations

Budget and Staffing: The budgets of the other states' health data functions range from $80,000 in Vermont to $5.7 million in New York. However, the New York program includes other functions not specifically tied to health data reporting. The state with the largest budget dedicated entirely to health data functions is Pennsylvania ($3 million). The average budget for the responding states is $1.1 million which is comparable to the FY-96 budget for the VHSCRC and VHI (approximately $1.5 million).

The number of staff assigned to other states' data functions range from 1 employee in Minnesota to 50 in Pennsylvania. The average number of staff in each state is approximately 9 FTEs. Currently, the VHSCRC has 21 positions authorized in the Appropriation Act; however, it has received approval to fill only 11 positions.

Funding Source: Most of the states (13) are funded substantially from state general funds. An additional 7 states are funded through a mix of state general funds and other sources. One state, Nevada, is funded through health insurance assessments. Eight states use provider fees or assessments to some degree to fund their operations; in six of these eight states, fees or assessments represent the primary or sole funding source.

Council/Board Composition: All but six states utilize a council or board to provide oversight to the activities of the health data organization. The number of council members ranges from 3 in West Virginia and Vermont to 21 in Pennsylvania. The average size of the councils in other states is 11. (Virginia has a total of 34; the VHSCRC and the VHI Board each have 17 members.) Overall, the states' councils have broad representation of hospitals, business/employers, physicians, consumers, and insurers.

The composition of the councils in two states, New Mexico and Pennsylvania, are of particular interest. New Mexico requires its Commission members to have no pecuniary or fiduciary interests in the health care industry for the prior three years. In Pennsylvania, 12 of the 21 members are business and organized labor representatives. Hospitals and physicians each have one representative.

Most States Are Collecting Both Hospital Discharge and Financial Data; Twelve of the 29 States Collect Nursing Home Data

With the exception of Kansas, which is just beginning its health data function, all of the states are collecting hospital information. Of the 28 states actively collecting hospital information, 19 collect both discharge and financial data. Six states collect only discharge data; three states collect only financial data.

Twelve of the 29 states collect some nursing home data; however, the kind of data that are collected varies widely among the states. Three states collect both financial and discharge data; two states collect only financial data; and one state collects only discharge data. The remaining six states collect various forms of nursing home data.

Most States Publish Standard Reports on Hospital Discharges, Utilization Rates, and Charge Information

Much of the health care data reporting is similar among the various states. For hospitals, standard reports such as utilization rates, discharge information (e.g. average length of stay), and charge information for various services and procedures are published. Those states which collect nursing home data produce basic reports about utilization, charges and available services.

Physician Reports: A few states (Colorado, Iowa, Pennsylvania, Wisconsin) currently report data on physicians or plan to do so in the near future. Colorado has authority to publish comparative hospital outcomes for physicians, but has not yet issued any reports. Iowa collects and reports physician billing information from third-party payers. Pennsylvania published a report on coronary artery bypass graft surgery which included risk-adjusted mortality rates for hospitals and physicians. (While New York did not respond to the survey, it has published a similar report on physicians regarding coronary artery bypass graft surgery.) Wisconsin currently does not collect physician data but is considering collecting this information in the near future.

Other Reports: Colorado will be publishing HEDIS measures voluntarily submitted by health plans. Missouri publishes several "Buyer's Guides" on selected services. These consumer guides are modeled after "Consumer Reports" and include patient satisfaction information.

Customized Reports: Several states, most notably Florida, Illinois, Pennsylvania, New York and Vermont, produce a large number of customized reports and analyses. Various organizations and individuals will contract with the state entity to produce anything from raw data to complete reports on various topics not covered in the standard reports. This type of reporting is similar to the kinds of analyses offered by VHI through Virginia's patient level data base.

The Data Initiatives in Three States (Colorado, Iowa, and Pennsylvania) Have Instituted More Advanced Systems by Collecting Outcomes and "Quality of Care" Data From Hospitals

Of those states responding to the survey, Colorado, Iowa and Pennsylvania have implemented significantly more advanced systems which include outcomes and quality of care measurements. In the other states, the data that are collected pertain only to financial issues and discharge

information such as utilization, average length of stay, and cost per day. In these three states, their respective systems also collect information regarding outcomes and the quality of care received by consumers. There may be other states with these capabilities; however, these three states are the only survey states which included this information in their responses.

MedisGroups/Atlas Outcomes System: Each of these states uses a computer system developed by a national firm, MediQual Systems, Inc., to collect and analyze clinical information about a patient's hospitalization. MediQual has developed an automated system, MedisGroups (now called the Atlas Outcomes), to collect and analyze the information. Briefly, the system involves trained medical record abstractors in the hospitals reviewing patient records and collecting clinical information, physical findings, laboratory data, and radiographic data. These "Key Clinical Findings" are entered into the Atlas Outcomes System computer algorithm which generates a "severity score." On average, patients with higher severity scores are sicker, have higher mortality rates, longer lengths of stay and cost more.

The Atlas Outcomes System incorporates the "severity score" of patients with hospital information on the number of deaths during hospitalization and the number of patients who were medically unstable after the first week of hospital treatment. The system then compares this information for each hospital to a national comparative database which includes similar information from over 100 hospitals across the country.

Expected Outcomes vs. Actual Outcomes: Based on the national comparative data base, the system produces statistics for each hospital which indicate the expected number of deaths with the actual number, and the expected number of patients who are medically unstable after one week, with the actual number. In this way, the hospitals and patients can make useful comparisons among hospitals on the quality of care received at each hospital.

Quality of Care and Outcomes Information Is Valuable Data, But Extremely Costly to Produce

The systems instituted in Colorado, Iowa and Pennsylvania represent some of the most advanced data systems in operation. The information which allows hospitals, providers and consumers to compare institutions on the outcomes and quality of care is a major advantage over the systems in place in Virginia and the other states. However, this data comes at a very high cost. A Pennsylvania hospital official indicated that the hospital utilizes seven data extractors to produce the information for the Pennsylvania report. The Health Care Financing Administration estimates the cost of this system to be $60.00

per data extraction that occurs at the hospital. Due to the high cost of generating this information, data typically are extracted for only selected diagnoses or conditions.

States Were Not Able to Provide Specific Information on the Level of Use or Perceived Value of Their Data

States generally were unable to specify how useful their data has been in their respective markets. However, few states reported having eliminated any reports due to a lack of use in the marketplace. While most perceive that their data is useful, and some included statistics on the number of data requests they receive, there was little information in the survey responses to determine the true value and use of the states' data initiatives.

Conclusions

Based on the information presented in the preceding sections of this report, a number of general conclusions can be reached regarding the major objectives of this study which are: (i) to evaluate the value and utility of the efficiency and productivity methodology, the patient level data base, and other health care data reports; (ii) the organizational structure and location of the VHSCRC and the patient level data base system; and (iii) the appropriate role of the Commonwealth in health care cost and quality initiatives. Accordingly, the following conclusions provide a framework for how Virginia should address the key issues regarding health care cost and quality data initiatives.

The Commonwealth Should Collect, Analyze and Disseminate Only That Data Which Produces Useful and Valuable Information in the Marketplace; Several of the Current VHSCRC Reports Appear to Have Little Value

While the VHSCRC has fulfilled its statutory mission of producing information as outlined in the Code, many of the reports currently produced appear to be of little use in the marketplace and have little or no value. These reports are: the Annual Charge Survey for Hospitals and Nursing Homes, the Annual Trends Report for both hospitals and nursing homes, the Commercial Diversification Survey for Hospitals, the Budget Filing requirements for hospitals, and the IRS Form 990 requirements for top executives of non-profit health care institutions.

Information provided by hospitals and nursing homes on charges and other financial information reported on the Medicaid Cost Reports to the Department of Medical Assistance Services could be used to produce similar reports on charges if a need for this information becomes apparent. Also, hospital information reported to VHI could be used to produce similar reports if necessary.

The Efficiency and Productivity Methodology and the Patient Level Data Base Appear to Hold the Most Promise for Producing Valuable and Useful Health Care Data; These Initiatives Should be Continued and Enhanced

With the exception of the nursing home industry, there is general agreement among the key players that the efficiency and productivity methodology is producing useful and valuable information; and that the quality of care indicators that are being incorporated in the next report for hospitals will enhance its utility and value. This initiative should be continued and refined as needed. Future reports should include not only the quality of care indicators, but also some evaluative measures that indicate what impact the report has had in improving hospitals' scores on key performance indicators.

The nursing home industry feels strongly that the efficiency and productivity methodology has no value for nursing homes. They argue that in an industry where 60-70% of its costs are paid by Medicaid and few if any beds are empty, the methodology has little relevance or value. However, the methodology was released just recently in December, 1994, and has had little time to prove whether it is valuable in the marketplace.

The patient level data base also is viewed as having potential value and utility in the marketplace. This initiative should be continued and enhanced. VHI should use the state-sponsored outpatient data to determine the utility and value of collecting and analyzing outpatient data on a broader basis.

Current Organizational Structure Is Duplicative and Should Be Revised

The current organizational structure, in which both VHSCRC and VHI perform similar duties in overseeing very similar functions, is duplicative and should be revised. Health care data collection and reporting functions should be consolidated and located in one entity.

The Commonwealth Should Play a Supportive Rather Than A Primary Role in Providing Health Care Data for the Private Sector and General Public

Consistent with Virginia's market-based approach, the appropriate role of the Commonwealth with respect to health data initiatives should be to support the efforts of the private sector, and provide a statutory and regulatory framework that facilitates the development and dissemination of this information in the marketplace. To the degree that the Commonwealth represents the only means by which useful and valuable data can be collected, analyzed and disseminated, the Commonwealth should fill this need. In short, the Commonwealth should play a supportive role in this endeavor, rather than the primary role.

The Commonwealth Should Enhance the Coordination and Use of Health Care Data in its Health Care Purchasing Activities

The Commonwealth purchases health care services through the state employee benefits program and Medicaid for roughly 800,000 persons. This vast purchasing power could be enhanced by closer coordination among the two agencies. A more coordinated approach to collecting, analyzing and using available data is one means of enhancing the cost-effectiveness of these programs. Requiring health plans which participate in the state employee benefits program and Medicaid to be accredited and to submit HEDIS-type "report cards" would provide important "quality" information to state employees and Medicaid enrollees. Given the size of the Commonwealth's purchasing power, this action could have a significant impact on the rest of the market in terms of providing information to enrollees on the quality of health plans.

If the Current Health Care Data Functions are Moved to a Non-State Entity, the Commonwealth Should Consider Assigning Explicit Responsibility to a State Agency for Monitoring the Financial Trends and Profitability of Hospitals and the Level of Community Support Provided

The data on hospitals that are collected by the Commonwealth include various information on hospitals' financial trends, profitability and level of community support. If these data functions are moved to a non-state entity, the Commonwealth should consider assigning explicit responsibility to a state agency for monitoring hospitals' financial trends, profitability and level of community support.

Policy Options

Based on the conclusions outlined in the preceding section, the following policy options are offered for consideration by the General Assembly in addressing: (i) the appropriate role of the Commonwealth in health care cost and quality data initiatives; (ii) the appropriate organizational structure and location of the Virginia Health Services Cost Review Council and the Virginia Patient Level Data Base; and (iii) the appropriate types of health care data initiatives that should be administered by the Commonwealth.

Option I: Maintain Status Quo

In Option I, there would be essentially no change in the Commonwealth's role with respect to health care data initiatives. Option I would continue the Virginia Health Services Cost Review Council (VHSCRC) in its current status, with no changes in its organizational structure, location, functions or responsibilities. The VHSCRC would continue to produce essentially the same health care cost reports as mandated by the Code of Virginia and would continue to modify and improve these reports as needed. No changes would be recommended regarding the state's relationship with Virginia Health Information, Inc. (VHI).

Option II: Eliminate All Current VHSCRC Reports Except the Efficiency and Productivity Methodology; Eliminate VHSCRC and Merge the Efficiency and Productivity Methodology into VHI's Functions

Option II would eliminate the following current reporting functions of the VHSCRC: Annual Survey of Charges - Hospitals; Annual Survey of Charges - Nursing Homes; Health Care Trends Report - Hospitals; Health Care Trends Report - Nursing Homes; Commercial Diversification Survey - Hospitals; Budget Filing Requirements for Hospitals; and IRS Form 990 information for nursing home and hospital executives. The efficiency and productivity methodology for hospitals and nursing homes would be continued. Option II also would eliminate the VHSCRC and merge the efficiency and productivity methodology into the functions of VHI.

Prior to implementing this Option, the current users of the reports could be consulted to determine whether their data needs can be met through the efficiency and productivity methodology and the information reported to the patient level data base.

The VHI Board should be consulted to determine if it believes the organization should assume responsibility for producing nursing home information. If VHI assumes this function, the composition of the VHI Board would have to be reconstituted to include nursing home representatives. If it is determined that VHI should not assume responsibility for nursing home reporting, consideration should be given to "decoupling" the nursing homes from the hospitals, and placing the efficiency and productivity methodology for nursing homes directly within DMAS.

The current funding mechanism of fees paid by hospitals and nursing homes to the VHSCRC would need to be revised if Option II is implemented.

Under Option II, VHI would have to be "linked" to or contracted by a state agency to retain its ability to issue regulations and receive state funds. Alternative locations within state government include DMAS, the Department of Health, the Secretary of Health and Human Resources. The State Corporation Commission is also an option as is done in North Carolina and Wisconsin.

Option III: Eliminate All Current VHSCRC Reports Except the Efficiency and Productivity Methodology; Eliminate VHSCRC and Merge the Efficiency and Productivity Methodology into VHI's Functions; Adopt Requirements for Hospitals to Submit Outcomes and Quality of Care Data Similar to That in Colorado, Iowa, and Pennsylvania and Have VHI Administer This Function

Option III would make the same reporting and structural changes as outlined in Option II. However, Option III calls for a significant expansion of the Commonwealth's health care data initiatives, and would represent a move toward the more advanced systems operating in other states. This option also would result in a significant increase in the cost of Virginia's current health care data initiatives. In this scenario, hospitals would utilize a system similar to the MediQual system in place in Colorado, Iowa and Pennsylvania to extract clinical information that would be used to develop outcome and quality of care measures as is done in these other states. VHI would be asked to incorporate this function into its overall responsibilities.

The same issues in Option II regarding fees, the composition of VHI's Board, and the "linkage" to state government would need to be addressed under this option. More importantly, the issue of how to pay for this expansion of health care data initiatives would need to be addressed.

Option IV: Direct the Department of Personnel and Training and the Department of Medical Assistance Services to Consider Requiring Health Plans Included in Their Respective Programs to Achieve National Accreditation and to Submit Plan Assessments or "Report Cards" For Inclusion in the Information Provided to Enrollees

Option IV recognizes that, as a purchaser of health care, the Commonwealth should provide its customers (state employees and Medicaid recipients) with useful information regarding the quality of health plans that are offered to them. In this role, the Department of Personnel and Training and the Department of Medical Assistance Services should consider requiring that plans offered through their respective programs achieve national accreditation (e.g. NCQA) and/or submit "report cards" such as HEDIS type data. This information could be included in the information that is provided to enrollees to help them select their health plans.

Option V: Assign Explicit Responsibility to the Department of Medical Assistance Services for Monitoring Hospitals' Financial Trends, Profitability and Level of Community Support

Option V recognizes that, should the VHSCRC be eliminated as discussed in Option II and all data functions are placed in a non-state entity, a state agency would need to be given explicit responsibility for monitoring the financial trends and profitability of hospitals as well as the level of community support provided. Option V would assign this responsibility to DMAS as part of its role in administering the Indigent Health Care Trust Fund.

Option VI: Request VHI to Publish HEDIS-Type Health Plan Assessments Voluntarily Submitted by HMOs and Other Health Plans

Option VI would expand VHI's role to include publishing HEDIS-type plan assessments or "report cards" that are voluntarily submitted by HMOs or other health plans. This option would represent an incremental step toward making this information available to consumers without involving a state mandate.

Option VII: Direct VHI to Review the Feasibility of Expanding its Current Base of State-Sponsored Outpatient Data to Include Additional Types of Outpatient and Physician Data

VHI currently collects outpatient data from the state employee health insurance program and the Medicaid program. Option VII would direct VHI

to review the feasibility of expanding its outpatient data base to include additional types of outpatient and physician data. As part of its review, VHI would need to identify the potential advantages, disadvantages, and costs of expanding its outpatient data base. The current state-sponsored data could be used to develop model "outputs" that would illustrate the potential value of expanding the data base to include physician data and other outpatient data.

APPENDIX A

GENERAL ASSEMBLY OF VIRGINIA -- 1995 SESSION

HOUSE JOINT RESOLUTION NO. 513

Directing the Joint Commission on Health Care to study the organization and effectiveness of Virginia's health care cost and quality initiatives.

Agreed to by the House of Delegates, February 4, 1995
Agreed to by the Senate, February 21, 1995

WHEREAS, health care cost inflation is a continuing problem in Virginia's economy; and

WHEREAS, the effectiveness of many medical procedures is uncertain, leading to wide variations in practice as well as unnecessary expenditures for medical services; and

WHEREAS, information about health care costs and quality has not been sufficient to allow consumers to make informed decisions in the choice of health care plans and providers; and

WHEREAS, as a catalyst for health care reform, the Commonwealth is committed to promoting public/private partnerships for developing consumer information on the cost and quality of health care; and

WHEREAS, in 1992 the General Assembly directed the Virginia Health Services Cost Review Council to develop a new methodology to measure the efficiency and productivity of health care institutions and to identify the most efficient and productive providers; and

WHEREAS, this methodology has been developed by the Williamson Institute of Virginia Commonwealth University under a contract with the Health Services Cost Review Council; and

WHEREAS, in 1993 the General Assembly created the Virginia Patient Level Data System, which is maintained by Virginia Health Information, Inc., a nonprofit, tax-exempt organization operating under a contract with the Health Services Cost Review Council; and

WHEREAS, the Virginia Patient Level Data Base is intended to allow purchasers to compare health care providers in terms of utilization rates, charges, and outcomes for various common or expensive inpatient and outpatient hospital treatments; and

WHEREAS, in 1994 the General Assembly directed the Health Services Cost Review Council to study the feasibility of developing an evaluation system which would allow consumers to compare health plans on measures of cost, quality, and accessibility as well as the role of the Commonwealth in developing such a system; and

WHEREAS, market forces are stimulating health care providers and health plans to place renewed emphasis on cost and quality management through such measures as internal continuous quality improvement programs, public reports on cost and quality indicators, and voluntary accreditation by the National Council on Quality Assurance; and

WHEREAS, the appropriate role of the Commonwealth in developing consumer information on the cost and quality of health care may change depending upon (i) the extent to which the Commonwealth, as a purchaser of health care, uses the information from the Health Services Cost Review Council and the Patient Level Data Base in selecting health care providers and health care plans; (ii) the extent to which the Commonwealth is willing to invest in ongoing research by and development and operations of the Health Services Cost Review Council and the Patient Level Data Base; (iii) the extent to which the private sector is willing to work with the state in supporting these initiatives; and (iv) the pace at which the private sector develops its own cost and quality measurement systems in response to market forces; now, therefore, be it

RESOLVED, by the House of Delegates, the Senate concurring, That the Joint Commission on Health Care be directed to study the organization and effectiveness of Virginia's health care cost and quality initiatives. The study shall include, but not be limited to, an evaluation of (i) the value of the efficiency and productivity methodology used by the Health Services Cost Review Council, including reports prepared for consumers; (ii) the value of the Virginia Patient Level Data Base, including reports prepared for consumers; (iii) the appropriate role of the Commonwealth versus the private sector as financier, researcher, administrator, and user of health care cost and quality data; and (iv) the appropriate organizational structure and location of the Health Services Cost Review Council and the Virginia Patient Level Data Base.

The Joint Commission on Health Care shall provide staff support for the study. All agencies of the Commonwealth shall provide assistance to the Commission, upon request.

APPENDIX B

Joint Commission on Health Care

Summary of Public Comments on Draft Issue Brief 4: Health Care Cost and Quality Data Initiatives

Comments regarding the "Health Care Cost and Quality Data Initiatives" Issue Brief were received from the following 16 interested parties:

The Virginia Hospital Association
Sentara Health System
The League of Virginia Health Systems
Virginia Association of Health Maintenance Organizations
The Virginia Chamber of Commerce
Virginia Health Care Association
Tidewater Health Care
Virginia Manufacturers Association
Virginia Health Information, Inc.
Richmond Area Business Group on Health
Virginia Association of Nonprofit Homes for the Aging
The Medical Society of Virginia
Virginia Commonwealth University-Medical College of Virginia
Williamson Institute for Health Studies
Mr. John Barton
Mr. Frank Medico

Policy Options Presented in Issue Brief

Seven policy options were presented in the Issue Brief for consideration by the Joint Commission on Health Care.

Option I: Maintain status quo.

Option II: Eliminate All Current VHSCRC Reports Except the Efficiency and Productivity Methodology; Eliminate VHSCRC and Merge the Efficiency and Productivity Methodology into VHI's Functions

Option III: Eliminate All Current VHSCRC Reports Except the Efficiency and Productivity Methodology; Eliminate VHSCRC and Merge the Efficiency and Productivity Methodology into VHI's Functions; Adopt Requirements for Hospitals to Submit Outcomes and Quality of Care Data Similar to That in Colorado, Iowa, and Pennsylvania and Have VHI Administer This Function

Option IV: Direct the Department of Personnel and Training and the Department of Medical Assistance Services to Consider Requiring Health Plans Included in Their Respective Programs to Achieve National Accreditation and to Submit Plan Assessments or "Report Cards" For Inclusion in the Information Provided to Enrollees

Option V: Assign Explicit Responsibility to the Department of Medical Assistance Services for Monitoring Health Care Providers' Financial Trends, Profitability and Level of Community Support

Option VI: Request VHI to Publish HEDIS-Type Health Plan Assessments Voluntarily Submitted by HMOs and Other Health Plans

Option VII: Direct VHI to Review the Feasibility of Expanding its Current Base of State-Sponsored Outpatient Data to Include Additional Types of Outpatient and Physician Data

Summary of Comments

There was general agreement among those submitting comments that the Virginia Health Services Cost Review Council (VHSCRC) reports identified in the issue brief as having little value and utility in the marketplace, indeed have little value. There also was consensus that the hospital and nursing home efficiency and productivity methodology and the Patient Level Data Base have greater value and utility. However, some commenters questioned the need to continue the efficiency and productivity methodology.

Most commenters recommended that the VHSCRC and Virginia Health Information, Inc. (VHI) be merged. There was general support for Option II, and agreement that the Commonwealth should play a supportive and not a primary role in health care cost and quality data initiatives.

Summary of Individual Public Comments

The Virginia Hospital Association (VHA)

Katharine M. Webb, Senior Vice President, stated that the Commonwealth is at a major crossroads concerning its role in sponsoring and supporting health care cost and quality data collection initiatives. Ms. Webb noted that private sector efforts are accelerating, and that the VHA continues to commit significant resources to these initiatives. She indicated that the VHA believes much of the current state sponsored data collection initiatives are not meeting market needs. Ms. Webb stated that purchasers and consumers want information on all aspects of the delivery system, and that any option that adds mandated reporting from only one element of the delivery system or does not have a clearly documented public policy purpose will fail to meet market demands, and will be opposed by the VHA.

Ms. Webb indicated that the VHA believes additional research is needed on this matter. VHA has contracted with a research firm to collect information on what data have utility and value for consumers and employers. With respect to restructuring the current state organizations responsible for data initiatives, the VHA supports eliminating the VHSCRC and transferring the efficiency and productivity methodology to VHI. The VHA also supports providing statutory authority to the Department of Health to require the submission of necessary data by all components of the health care delivery system.

Sentara Health System

Ms. Patti Forrester, Director of Public Affairs, commented that the current VHSCRC reports have low public awareness and demand. She indicated that if the efficiency and productivity methodology is useful, it may be more efficient to merge it with the work being accomplished by VHI. Ms. Forrester noted that it does not seem appropriate for the Commonwealth to mandate health plan assessments or "report cards" at this time. She indicated that the state should let market forces continue to drive the issue of health plan "report cards."

The League of Virginia Health Systems

Donald L. Harris, Senior Vice President of Government Relations for INOVA Health System, commented that the League of Virginia Health Systems (the League) agrees that several of the VHSCRC reports have little value. Mr. Harris commented that the League questioned the value of continuing the efficiency and productivity methodology. He indicated that the League supports the Patient Level Data Base, and that it should be expanded to outpatient care on a cost-effective basis. Mr. Harris also stated that the League would support Option III with further analysis of the need for the efficiency and productivity report and with an assessment of the costs and benefits of submitting outcomes and quality data.

Mr. Harris commented that the League had no problems with Option IV and Option V, and concurred with Option VII. He mentioned that the League questions mandating data reporting from certain segments of the marketplace (hospitals and nursing homes) while making similar types of data collection voluntary for health plans.

Virginia Association of Health Maintenance Organizations (VAHMO)

Ms. May H. Fox, Executive Director, indicated that VAHMO concurs with many of the general conclusions in the issue brief. She noted that the Association supports continuation of the efficiency and productivity methodology and the Patient Level Data Base, and supports Option II. She indicated that the VAHMO strongly supports a streamlined organizational structure with the private sector taking the lead in producing data that is relevant to consumers and purchasers.

Ms. Fox commented that the VAHMO opposes Options III - VII. She stated that there is no evidence to suggest that Virginia would be well served by implementing quality of care data requirements such as those in Colorado, Iowa and Pennsylvania. Ms. Fox commented that the VAHMO supports voluntary, standardized HEDIS reporting, but opposes any requirement for HMOs to submit variations of the HEDIS data set. She stated that it is premature to expand VHI's authority to collect additional outpatient data.

The Virginia Chamber of Commerce

Ms. Sandra D. Bowen, Senior Vice President, indicated that the Virginia Chamber of Commerce supports transfer of the efficiency and productivity methodology to VHI. She indicated that the other VHSCRC reports appear to have limited use and value. Ms. Bowen also noted that VHI is providing a very important function and should be the primary avenue for analysis, coordination and distribution of data. The Virginia Chamber of Commerce also believes that VHI should be directed to examine the expansion of its outpatient data. Ms. Bowen indicated that there is no need at this time for VHI to publish HEDIS report cards due to the current activities in the private sector.

Virginia Health Care Association (VHCA)

Ms. Mary Lynne Bailey, Vice President of Legal and Government Affairs, commented that the VHCA believes the reports issued by the VHSCRC are of little use to the public, insurers, and employers. She indicated that the efficiency and productivity methodology for nursing homes should be useful in the future and should evolve into quality indices for nursing homes. Ms. Bailey stated that VHCA supports Option II and that VHI should be "linked" to the Department of Health. Ms. Bailey commented that the Commonwealth should serve as a mandating authority for data in the marketplace and allow the private sector to address health care costs.

Tidewater Health Care (THC)

Douglas L. Johnson, President and Chief Executive Officer, recommended elimination of the VHSCRC reports found to be of little value. Mr. Johnson noted that THC has not found these reports to be useful in making decisions. He stated that THC supports Option II. He recommended that the Commonwealth continue to reduce the amount of duplication in reports submitted to state agencies.

Virginia Manufacturers Association (VMA)

Mr. Robert P. Kyle, Vice President, stated that the VMA supports Option II. Mr. Kyle also noted that the VMA supports a move toward "quality of care" data and the Patient Level Data Base. Mr. Kyle commented that VHI

is a worthwhile effort to ensure participation by key stakeholders in the collection and analysis of health care data.

Virginia Health Information, Inc. (VHI)

Mr. Michael T. Lundberg, Executive Director, indicated that VHI believes the Commonwealth's role should be supportive and that it is willing to continue the status quo. Mr. Lundberg also noted that if VHI's contractual duties are expanded, it is prepared to assume them. He expressed concern about any structure that would be restrictive or controlling of VHI activities.

Richmond Area Business Group on Health (RABGOH)

Ms. Kim S. Barnes, Executive Director, indicated that RABGOH supports continuation of the efficiency and productivity methodology through an independent, nonprofit entity. Ms. Barnes suggested that a financial impact study be conducted to determine if costs savings will result from shifting the methodology from the VHSCRC to VHI. She also commented that private sector initiatives, such as RABGOH's HEDIS project, be allowed to progress. Ms. Barnes noted that state data initiatives should not be controlled by state agencies that purchase care due to possible conflict of interest.

Virginia Association of Nonprofit Homes for the Aging (VANHA)

Ms. Marcia A. Melton, Director of Legislative Services, commented that VANHA believes the reports produced by the VHSCRC are of little value to consumers. She noted that VANHA supports elimination of the VHSCRC, Option II, and the development of public-private partnerships in achieving a more efficient state government.

The Medical Society of Virginia (MSV)

Ms. Madeline I. Wade, Director of Legislative Affairs, stated that the MSV encourages the Joint Commission to look favorably on Options II and III. She indicated that the Commonwealth should consider moving to Option II with plans to eventually expand to outcomes and "quality of care" measures.

Virginia Commonwealth University-Medical College of Virginia (VCU-MCV)

Dr. John E. Jones, M.D., Vice President for Health Sciences, commented that VCU-MCV believes changes are needed in the current organizational structure to reduce inefficiencies and promote a centralized data repository for the Commonwealth.

Williamson Institute for Health Studies

Dr. Ramesh K. Shukla, Ph.D., Director, commented that there is duplication in the current functions, structure and resources of the VHSCRC and VHI. Dr. Shukla indicated that VHSCRC and VHI should be combined, and that the data collection activities should reside in a state agency which has a culture and orientation to support a market-based approach. He commented that the State Corporation Commission would be an appropriate agency. Dr. Shukla recommended that the state agency responsible for data activities contract with one entity for data collection and contract with an academic institution, such as the Williamson Institute, for data analysis.

Mr. John Barton

Mr. Barton, an insurance agent, indicated that he has used VHSCRC data that appeared in newspaper articles and, on occasion, has requested other data from the VHSCRC.

Mr. Frank Medico

Mr. Medico, a member of the VHSCRC, commented that he questioned the overall efficiency and effectiveness of state government's health care efforts. Mr. Medico suggested a legislative study be conducted to review the myriad of state entities involved in health care issues. He indicated support for eliminating VHSCRC reports having limited utility, and allowing the private sector to play the primary role in data collection initiatives. He recommended eliminating the VHSCRC and placing essential data functions in one agency. He also recommended surveying

consumers to determine whether the efficiency and productivity methodology should be retained.

JOINT COMMISSION ON HEALTH CARE

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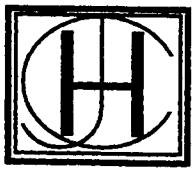
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