

Medicare's Push for Quality Health Care

Richard G. Stefanacci, DO, MGH, MBA, AGSF, CMD

It is often stated that the 3 measures of a health care system are access, cost, and quality. While much of the focus has been on the cost component (price times utilization), it has been more difficult to define and measure quality. One reason for this is that quality is not always directly affected by the cost of health care, since simply adding more dollars does not necessarily improve quality. Several studies, including that by Fisher et al., have demonstrated that in regions of high Medicare spending, neither better quality nor access appear to be achieved.¹ These researchers found that higher spending was the result of a greater use of inpatient-based and specialist-oriented patterns of practice, suggesting that better outcomes are the result of new and better approaches to providing quality health care.

Since its beginning in 1965, Medicare has been keenly interested in assuring quality care for its beneficiaries (Table 1). This push for quality health care evolved slowly, first focusing on a regulatory approach, while at the same time building assistive programs for providers to achieve quality care delivery standards. Most recently, Medicare has moved to effecting the demand and supply for quality services by utilizing market forces.

In this new approach, Medicare has undertaken a strategy of measuring, reporting, and rewarding performance in health care through both the demand and supply side. On the demand side, this is accomplished using public reporting of quality data. The rationale is that consumers will be driven toward higher-quality providers and away from lower-

quality providers. On the supply side, the focus is on pay-for-performance measures and a reimbursement system that rewards quality providers financially, providing them with the resources they need to expand their services.

Realizing the importance of making systemwide changes to improve the quality of care, the Medicare Payment Advisory Commission (MedPAC) has set 3 major priorities:²

- Utilizing financial incentives to improve quality
- Using disease and care management programs to better address the need to coordinate care for those with chronic conditions
- Exploring the relationship between cost and quality

To successfully achieve quality outcomes, changes are being forced upon Medicare provider practices. Many of these changes are likely to

involve significant practice re-designs.

Regulatory Approach

Previously, Medicare's initial approach to achieve quality outcomes was strictly regulatory, with the primary focus on fraud and abuse prevention. Regulation against fraud and abuse is thought in many circles to be the best defense against these problems, which are currently estimated to cost Medicare and Medicaid about \$33 billion annually. Medicare fraud is defined as purposely billing Medicare for services that were never provided or received (Table 2).

This points out the importance of documentation to assure that the clinical evidence supports the amount and service being billed to

Table 1.
Medicare Drivers for Quality Health Care¹

- Regulation of performance
 - Fraud and abuse
- Helping improve performance
 - Quality improvement organizations
- Measuring, reporting, and rewarding performance
 - Demand side (public reporting)
 - Supply side (pay for performance)

Medicare. This is not to say that Center for Medicare and Medicaid Services (CMS) regulations all fall in the area of fraud and abuse. In the area of nursing home care, for example, state surveyors are armed with volumes of regulations to enforce such matters as food temperature and medication storage.

In the move toward improving the quality of health care, many plans have been proposed. Steinberg proposed 4 actions to improve the quality of care:³

- 1) Measuring and reporting routinely on quality of care at both the national and provider levels
- 2) Making greater use of information technology
- 3) Drawing on the power of patients to improve the quality of care they receive and their health outcomes
- 4) Redesigning current financial incentives so as to not discourage quality improvements

Similarly, CMS has shifted from a pure regulatory approach to achieve performance measures to an approach that provides resources and incentives to improve results. Evidence that regulations alone have not achieved the desired results has been well documented. The public health report, *Healthy People 2010*, identified wide gaps between public health performance goals and actual achievements on many measures.⁴ A similar report from the Institute of Medicine (IOM) showed serious problems resulting from medical errors.⁵ During Medicare's first 3 decades, little public reporting of data was available. Even in the commercial world, data were limited to information available in the

Table 2.

Examples of Medicare Fraud

- Billing Medicare or another insurer for services or items that the beneficiary never obtains
- Billing Medicare for services or equipment that are different from those the beneficiary actually receives
- Using another person's Medicare card to obtain medical care, supplies, or equipment
- Billing Medicare for home medical equipment after it has been returned

Table 3.

CMS Systems Strategies for Improving Quality⁷

- Working through partnerships between and within CMS and other federal and state agencies and nongovernmental partners, including health professionals
- Publishing quality measurements and information, including measures directed toward beneficiary, professional, provider, and purchaser audiences
- Paying for health care in a way that expresses CMS' commitment to support providers and practitioners for improving quality and avoiding unnecessary costs, rather than directing more resources to less effective care
- Assisting practitioners and providers in taking advantage of CMS quality initiatives and making medical care more cost-effective, in particular, through greater use of electronic health records
- Making CMS an active partner in driving the creation and use of information about the benefits of bringing effective health care technologies to patients more rapidly and helping physicians and patients use treatments more effectively

Health Plan Employer Data and Information Set (HEDIS[®]) and, to a much lesser degree, the Diabetes Quality Improvement Project. CMS began its move in the collection and use of data on a grassroots level through peer review organizations (PROs), now referred to as Quality Improvement Organizations (QIOs), which systematically promoted improvements in quality measures that were tracked using voluntary, collaborative, and educational approaches.

The movement away from regulations is in part due to the fact that quality problems persist despite a decline in deficiencies. In addition, there is concern that,

over time, the enforcement of regulations will decline.⁶

A Change in Direction

CMS has laid the groundwork for its "Quality Improvement Roadmap," by summarizing 5 system strategies (Table 3).⁷

An example of this can be seen in the Doctors Office Quality Project⁸. The goal of this project is to define overall quality measures that assess and strategies that improve clinical performance in providing ambulatory care for persons with chronic disease. The project provides tools that physicians and their staff use to achieve excellence in care.

Helping Improve Performance

The realization that the negative pressure of regulations can affect quality only so much, and that additional resources are required to help providers achieve better outcomes, provided the rationale for QIOs. Under CMS direction, a national network of 53 QIOs is now responsible for each US state, territory, and the District of Columbia. QIOs work with providers and patients to improve delivery systems so that patients, particularly underserved populations, get the right care at the right time. On the regulation side, QIOs are responsible for ensuring that payments are made only for medically necessary services and investigating beneficiary complaints about quality of care.

To achieve its goals, the QIO Program assists providers in producing a quality result through delivery of effective, efficient, safe, timely, patient-centered, and equitable health care. QIOs do this by focusing on measurements, technology, processes, and culture. For more details on how QIOs operate, see “Medicare’s QIO Program: 8th Statement of work,” by Dr. Andrew Miller, Director of Physician Services at New Jersey’s federally designated QIO, which appears on page 21 of this issue.

Another QIO is the Beneficiary Complaint Response Program (BCRP). The BCRP emphasizes ways to work with physicians and practitioners in the community to improve the quality of care for Medicare beneficiaries.

Despite QIO efforts, there remains room for improvement. A nationwide study reported a substantial improvement in the quality of

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care delivered to Medicare beneficiaries between 1998-1999 (baseline) and 2000-2001 (follow-up) consistent with QIO activities during that period.⁹ However, the cross-sectional data did not provide conclusive information regarding the degree to which the improvement in care could be attributed to QIOs efforts.

Measuring, Reporting, and Rewarding Performance in Health Care

In its landmark report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, the IOM concluded that, “What is needed is a series of actions that, taken together, will create an environment that fosters and rewards improvement.”¹⁰

Quality measurement and reporting in health care are crucial for identifying areas in need of improvement, monitoring progress, and providing consumers and purchasers with comparative information about health system performance. Although several measurement systems are used to assess ambulatory, hospital, and

long-term care, a systematic assessment of quality across the spectrums of care is lacking. Spurred by rising costs and lagging quality improvement, large purchasers, health plans, and others have developed and implemented a variety of approaches that seek to reward high performance and create incentives for quality improvement. Efforts to improve and increase care measurement and align the incentives of providers through pay-for-performance programs are essential building blocks in developing a health care system that performs more effectively and efficiently. Federal leadership is important to provide consistency to measurement and incentive systems so that the nation can gain the full value of these tools.

The evidence of quality shortcomings is substantial and growing. A few examples are presented in Table 4.

To cope with rising costs, employers have shifted more of the cost of health insurance to employees and their families, and requested that they take a greater role in decisions about their care. This model of consumer-directed health care aims to give patients incentives to make informed decisions and choose necessary cost-effective care. However, this model assumes that consumers have sufficient information about the quality, performance, and costs associated with hospitals, doctors, health plans, and others who deliver care. In general, consumers report that they do not have this kind of information.

To help consumers access this information, companies like HealthGrades have been developed. Located in Golden, Colorado,

HealthGrades is the leading US health care ratings organization, providing ratings and profiles of hospitals, nursing homes, and physicians to consumers, corporations, health plans, and hospitals. Millions of consumers and hundreds of the nation's largest employers, health plans, and hospitals rely on HealthGrades' independent ratings to make health care decisions based on the quality of care. Visitors to HealthGrades.com can find quality ratings of the nation's 5,000 hospitals and 16,000 nursing homes, as well as in-depth profiles of more than 650,000 physicians. As a leader in the consumer revolution in health care, HealthGrades receives more than 2.5 million visitors to its consumer Web site each month. It is thought that public reporting of quality data will drive the medical market on the demand side toward more consumer-driven healthcare. Again, the thought is that consumers will choose to use higher rather than lower quality providers.

Furthermore, CMS requires health care providers to collect and monitor data on specific quality indicators (available at: www.medicare.gov). These requirements differ by type of provider, with nursing homes separate from hospitals, home care, and physicians. In addition to these quality measures, CMS has begun to publicize quality information on specific providers in an effort to increase the demand for providers who achieve the highest level of quality. The objective of this approach is to create an incentive for providers to achieve the quality goals that have been set forth by CMS. This concept has been suggested to be effective

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tive on the basis of research showing that nursing home residents and their proxies respond to quality data by changing providers if necessary.¹⁶

Today, the Medicare payment policy is structured so as to align payments with provider performance. MedPAC is required to consider a variety of measures because the direct relevance, availability, and quality of information in each potential indicator varies among providers.² In the development of

measurements, the focus started in the areas of structural capacity and process standards before moving to outcome measures. Reasons for measuring these starting points before moving to outcome measurements include:¹⁷

- There is more consensus on appropriate processes
- Measuring processes of care is generally easier, with no need for risk adjustment
- It is easier for practitioners to identify and fix the reasons why critical processes of care are not being met
- It takes years to calculate the effect of many outcome measures

However, there are a number of obstacles that make it difficult to drive the medical market on the demand side through the use of public reporting of quality data. Specific barriers to consumer-driven value-based purchasing are identified in Table 5.

Even following these guidelines, consensus regarding appropriate

Table 4.

Examples of the Lack of Quality in US Health Care

- Nearly 80,000 people die each year because they do not receive evidence-based care for such conditions as high blood pressure, diabetes, and heart disease¹¹
- On average, evidence-based care is provided only 55% of the time, reflecting either underuse or overuse of necessary medical care¹²
- As many as 98,000 hospitalized patients die each year as a result of preventable medical errors⁵
- The proportion of elderly patients with pneumonia who receive recommended pneumococcal screenings or vaccination in the highest-performing state is 7.5 times higher than in the lowest-performing state¹³
- Medicare expenditures for care given during the last 2 years of life is twice as high in Los Angeles than in Sacramento¹⁴
- The quality of hospital care varies widely, not only by geographic region and hospital type, but also across conditions within individual hospitals¹⁵

quality measures is not always found. According to a review by Davis, “Quality cannot be reflected in a single, meaningful criterion because it involves many criteria emerging from preferences of multiple constituencies—policymakers, health care professionals, administrators, owners, investors, third-party insurers, and consumers. Such values and preferences may overlap, but they may conflict as well.”¹⁹

In determining which disease management quality initiatives are important to measure, the following criteria are recommended:

- The disease is prevalent and a major source of morbidity or mortality in the Medicare population
- There is strong scientific evidence and practitioner consensus that there are processes of care that can substantially improve outcomes
- Reliable measurement of the delivery of these processes is feasible
- There is a substantial “performance gap” between current and desirable performance
- There is at least anecdotal evidence that QIOs can intervene effectively to improve these performance measures

As a result, the first series of measures focused on acute myocardial infarction, heart failure, stroke, treatment and prevention of pneumonia, breast cancer, and diabetes.

Nursing Home Quality Measures

The Department of Health and Human Services (DHHS) has devel-

CMS requires health care providers to collect and monitor data on specific quality indicators.

oped a national Nursing Home Quality Initiative to improve the quality of nursing home care. A critical part of this initiative is CMS’ posting of 10 quality indicators for every nursing home.²⁰ These “report cards” are intended to be used by consumers to make informed decisions and motivate providers to improve their care. Compared with the past approach of focusing on the process of care, this CMS quality initiative is a major redirection toward emphasis on the health care needs of the frail elderly, instead of the needs of the institution.

In a study designed to develop a

quality measurement tool and reporting format for long-term care (LTC) facilities, Moxey et al. concluded that there are many challenges to quality measurements in this setting, including the lack of a uniform definition of quality, the existence of multiple domains for measurement, and the inevitable and often unrecognized multitude of potential perspectives and regulatory influences that emphasize measurement only of poor quality.²¹ Their paper was based on the work done by a Project Advisory Committee (PAC) that was composed of 9 members comprised of nursing home administrators, medical directors, a geriatric nurse practitioner, and gerontologic and quality researchers. Between September 1999 and May 2000, the group developed the following clinical indicators for LTC facilities and residents:

- Use of 9 or more different medications
- Prevalence of occasional/frequent bladder or bowel incontinence without a toileting plan
- Prevalence of weight loss

Table 5. Barriers to Consumer-driven Value-based Purchasing¹⁸

Barriers related to quality of care data

- Limited availability of data
- Burden associated with collecting or obtaining data
- Generally poor quality of data, including insufficient level of detail and lack of timeliness

Barriers related to quality measurement

- Lack of agreement on standardized performance measures
- Difficulty in interpreting existing performance measures (eg, what they actually measure, what the expected level of performance is, and how important any single measure is in relation to others)
- Lack of consistency in findings across multiple measures
- Measures focused on care processes, rather than patient outcomes

- Incidence of decline in late-loss activities of daily living
- Prevalence of antipsychotic use in the absence of psychotic or related conditions
- Prevalence of daily physical restraints
- Prevalence of little or no physical activity

Hospital Quality Measures

CMS hospital quality measures come from data voluntarily submitted by hospitals for public reporting. The information is intended to illustrate how quality of care can vary between hospitals. Currently, the quality information relates to the care given for 3 serious medical conditions that are common in people with Medicare:

- Myocardial infarction
- Congestive heart failure
- Pneumonia

Data are available from CMS through a partnership with the: American Association of Retired Persons (AARP), American Federation of Labor-Congress of Industrial Organizations (AFL-CIO), American Medical Association (AMA), Agency for Health Care Research and Quality (AHRQ), American Hospital Association (AHA), Association of American Medical Colleges (AAMC), Federation of American Hospitals (FAH), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and National Quality Forum (NQF). CMS first attempted to collect this information on a purely voluntary basis, but could not garner sufficient interest from hospitals. When voluntary participation failed, CMS tied submission of quality data to payments for services

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es administered to Medicare beneficiaries. Today, hospitals that fail to submit data are not eligible for the Medicare-related increases applied to the payments, which can translate to as much as a 0.4% reduction in revenue for some facilities.

Physician Quality Measures

Medicare payments for physician services are made on the basis of a fee schedule that has been in place since 1992. The Medicare fee schedule is intended to relate payments to the actual resources used in providing health care services. The fee schedule assigns relative values to services that reflect physician work (ie, time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs. These relative values are adjusted according to geographic locations.

Generally accepted performance measures for physicians, such as HEDIS® or the AMA Physician Consortium for Performance Improvement™ (AMA-PCPI) measures of ambulatory care, tend to focus on delivery of preventive care, primary care disease management, and general care for the elderly.

The National Committee for Quality Assurance (NCQA), in collaboration with Mathematica

Policy Research, AMA, and the AMA-PCPI, recently released the first in a series of physician quality measures for public comment that focus on specialty care. The measures will be considered for use by CMS to capture data about the quality of care delivered to Medicare beneficiaries. The initial quality of care measures focused on the primary care provider, while these new measures consider care delivered by specialists and subspecialists.

The 8 sets of specialty measures will be released for public comment in 3 phases. The measures currently released for public comment assess aspects of eye care, osteoporosis, and perioperative care. Over the next few months, measures related to stroke care, skin cancer, geriatrics, emergency care, and gastroesophageal reflux disease will be released for public comment. The entire set of specialty measures is available at: www.ncqa.org.

Supply Side

Just as data can be used to drive demand for services, CMS is using data to drive supply by increasing the financial incentives given to high-quality providers through pay-for-performance initiatives, allowing them to obtain the resources they need to expand their services. Medicare is testing 2 quality-based bonus reimbursement models for hospitals and large physician groups. In hospitals, Medicare is awarding bonus payments on the basis of the hospitals' performance on evidence-based quality measures for inpatients with heart attacks, heart failure, pneumonia, coronary ar-

tery bypass graft surgery, and hip and knee replacements. Within these 5 clinical areas, CMS will evaluate hospital performance on 34 measures. The Physician Group Practice Demonstration tests a hybrid payment method of paying physicians by combining Medicare fee-for-service payments with a bonus pool derived from the savings achieved through the improved management of patient care and services.

The pay-for-quality concept is not new. For years, insurers such as Independence Blue Cross and Highmark Blue Cross/Blue Shield have offered reimbursement bonuses, in addition to their capitation payments, to primary care physicians who follow clinical guidelines (eg, HEDIS®). There is a growing belief that current payment systems not only fail to reward or encourage quality and quality improvement,

but at times penalize these efforts. Many payment systems pay for each service rendered on a fee-for-service basis. As a result, if a hospital, physician, or other provider performs fewer or less intensive services by following evidence-based guidelines, the organization or provider receives less money. As the IOM states in *Crossing the Quality Chasm: A New Health System for the 21st Century*, policymakers must align payment incentives with the drive to improve quality.¹⁰

Last summer, the AMA House of Delegates amended and approved the AMA Principles and Guidelines for the Formation and Implementation of Pay-for-Performance Programs.²² As the pay-for-performance concept becomes more commonplace, the physician community will work to ensure that these programs are positively structured and appropriately ap-

plied. The AMA believes that pay-for-performance programs must be aligned with 5 specific principles:

- Ensuring quality of care
- Fostering the relationship between patient and physician
- Offering voluntary physician participation
- Using accurate data and fair reporting
- Providing fair and equitable program incentives

The American Geriatric Society (AGS) also has developed a position statement with regard to pay-for-performance programs.²³ The Pay for Performance Position Statement appears on page 44 of this issue

Changing the System

Making adjustments to one's practice to maximize the quality measures that it is measured by will take considerable effort. Of course, practices should utilize existing resources, such as those available through their local QIO. In addition, in looking to redesign our systems, we would do well to take into account the IOM Committee on Quality of Health Care in America recommendations:¹⁰

- Care based on continuous healing relationships; in many cases, this will be with a physician, but if not a physician, then a nurse or another health professional can provide such continuing relationships
- Customization of care based on patients' needs and values
- The patient as the source of control
- Shared knowledge and free flow of information
- Evidence-based decision-making
- Safety as a systems property—the

Table 6.

Development of Clinical Records for Quality Data Assessment²⁴

Essential features of clinical records for quality data assessment

- Specify data elements
- Establish linkage capability among data elements and records
- Standardize the element definitions
- Are automated to the greatest possible extent
- Specify procedures for continually assessing data quality
- Maintain strict controls for protecting security and confidentiality of the data
- Specify protocols for sharing data across institutions under appropriate and well-defined circumstances

Preparing for quality data reporting

- Expand and improve the capture and use of currently available data
- Create an environment that rewards the automation of data
- Improve the quality of currently automated data
- Implement national standards
- Improve clinical data management practices
- Establish a clear commitment to protecting the confidentiality of enrollee information
- Utilize careful capital planning

PROVIDER ACTION

Impact to You

Understanding Medicare's push for quality health care is important, as this will directly impact the systems operating within one's practice. CMS will use quality measures for reimbursement decisions in different care settings. In addition, the move toward consumer-driven health care, where consumers will seek care from high-quality providers, will directly impact the demand for one's services. Thus, quality measures will directly influence the demand and reimbursement for a provider's services.

What You Need to Know

Based on one's practice type and setting of care, it is essential to know which quality indicators will be measured and how to improve their scores.

What You Need to Do

Based on the knowledge of which quality measures are important, develop systems in one's practice to maximize these measurements. These systems are likely to include the use of electronic medical records. In addition, the development of a relationship with a local QIO will be helpful in developing systems to maximize quality measures through practice improvements.

system should be transparent and patients should be able to understand everything occurring, both in individual care and care that is provided by institutions

- Transparency—patients should have access to information about system performance
- Anticipation of needs
- Continuous decrease in waste
- Cooperation among clinicians

Many of these recommendations require the use of a true care team model, placing the patient at the center of the process and utilizing electronic medical records for more efficient and effective assessment and use of quality measures (Table 6).

In the end, the movement by CMS toward quality measures as a means to push the demand and supply of health care provider systems will have profound effects on how one practices in ways we can only now start to imagine, but clearly need to in the near future.

MPM

Richard G. Stefanacci, DO, MGH, MBA, AGSF, CMD, is Editor-in Chief of *Medicare Patient Management* and the Founding Executive Director of the Health Policy Institute of University of the Sciences in Philadelphia, PA. He also held the position of CMS Health Policy Scholar 2003-2004.

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