

C H A P T E R

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**Influencing quality in
traditional Medicare**

R E C O M M E N D A T I O N S

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2B The Secretary should ensure that systems for monitoring, safeguarding, and improving the quality of Medicare beneficiaries' care are, to the extent possible, comparable under traditional Medicare and Medicare+Choice and that the systems are coordinated with each other as needed to maximize opportunities to reach quality improvement goals.

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2C The Secretary should ensure that Medicare works with other interested parties to promote the development and use of common, core sets of quality measures that represent the full spectrum of care obtained by beneficiaries.

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2D The Congress should provide HCFA with demonstration authority to test various mechanisms—such as payment incentives, preferred provider designations, or reduced administrative oversight—for rewarding health care organizations and providers that exceed quality and performance goals to counterbalance existing penalties for substandard performance.

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2E The Secretary should ensure that the methods and mechanisms used to influence quality under traditional Medicare are consistent with best practices used by private health plans and purchasers.

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2F The Secretary should develop and disseminate consumer-oriented information on quality of care to help beneficiaries compare enrollment options and providers. This information should include geographic area-specific information on the quality of care furnished to beneficiaries enrolled in traditional Medicare and provider-specific information on the quality of care furnished by health care facilities and practitioners participating in the program.

Influencing quality in traditional Medicare

As Medicare continues its transition from a relatively passive bill payer to a more active purchaser of health care services, policymakers will need to look closely at the program's systems for ensuring health care quality for beneficiaries who obtain care under all types of health care financing and delivery arrangements. In Medicare, as in the private sector, the strategies, techniques, and activities used to safeguard and improve quality have evolved differently under indemnity insurance and managed care. Because of historical objectives, structural limitations, and legislative restrictions, fewer (and different) approaches are now used under traditional Medicare, compared to Medicare+Choice.

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Stakeholders throughout the health system are beginning to appreciate the existence of a great wealth of opportunities to improve the quality of health care. Although recent concerns about quality have centered on managed care, this exclusive focus is unwarranted. Health care quality problems—and opportunities for improvement—are not confined to one type of payment system. As noted by the President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry (1998) and as evidenced by a growing and compelling health services research literature, quality problems are real, measurable, and found across all types of health care settings. The Institute of Medicine’s National Roundtable on Health Care Quality likewise has reported that serious and widespread quality problems occur with approximately equal frequency in managed care and fee-for-service (FFS) systems of care (Chassin et al. 1998).

The Medicare Payment Advisory Commission (MedPAC) supports efforts by the Health Care Financing Administration (HCFA) to use its purchasing power to improve the care beneficiaries obtain under the Medicare+Choice program and would like to see similar attention extended to the traditional program, which continues to serve most beneficiaries.¹ State-of-the-art systems for monitoring, safeguarding, and improving health care quality must be developed and implemented for the Medicare program as a whole. Using uniform quality assurance and improvement approaches, to the extent possible, would ensure a level playing field for health care providers and comparable protections for beneficiaries. Coordinated systems also offer the advantage of ensuring programwide attention to defined priorities to improve beneficiaries’ health and functional abilities.

With these objectives in mind, MedPAC offers recommendations to promote both consistency and innovation in Medicare’s quality initiatives. The Secretary of Health and Human Services should ensure that Medicare’s efforts to promote quality in the traditional program are comparable to, and coordinated with, its efforts to address the care furnished in Medicare+Choice plans. Those efforts also should be consistent with best practices of private health care purchasers and health plans. The Secretary should define goals for quality improvement in Medicare and work with other interested parties to identify core sets of quality measures to evaluate success in meeting those goals and to provide information for beneficiaries to use in comparing enrollment options and providers. Furthermore, Medicare should create incentives for quality improvement by rewarding health plans and providers that exceed performance goals.

This chapter begins with an overview of quality assurance and improvement in Medicare that describes the origins of these efforts and underlying reasons why they have evolved differently in managed care compared with the traditional program. It then describes steps needed to move toward comprehensive quality assurance in Medicare, noting that quality systems for Medicare+Choice and the traditional program must be developed and directed in tandem if they are to fully achieve their intended effects. The final section looks at different strategies used by purchasers and health plans to influence quality and examines how those strategies are used in Medicare. It identifies important current differences in Medicare between Medicare+Choice and the traditional program and assesses the challenges to be addressed as the program works to ensure beneficiary safety, help providers improve care, promote coordination and management of care, make quality-based purchasing and payment decisions, and empower beneficiaries as informed health care consumers.

Medicare quality policy: overview and current issues

As a better understanding of the nature and extent of quality problems has spread through the health system, attention has turned to the policy question of how to create systems to foster continual improvements in patient care. As the largest payer for health care services and a de facto regulator of the health system, Medicare can play a pivotal role in influencing health care quality by developing and using such systems.

The evolving rationale for Medicare’s quality initiatives

Given the dearth of data on health care quality up until recent years, policymakers’ concerns about quality of care historically have related to efforts to control health care costs. The root source of these quality concerns was the fear of repercussions associated with introducing financial incentives to withhold care, combined with a common assumption that providing more care necessarily meant obtaining better care.

These concerns are evident in the history of quality systems in the Medicare program. The introduction of the prospective payment system for hospitals led directly to the development of the peer review system, which was designed to ensure that medically necessary care was provided in the most appropriate setting.² The rise of Medicare managed care, under which plans are paid prospectively to meet beneficiaries’ health care needs irrespective of the quantity of services delivered, similarly led to the development of the Quality Improvement System for Managed Care (QISMC), a program that will require Medicare contractors to make significant investments in systems to improve care and tools to show they have done so.

1 Approximately 84 percent of Medicare beneficiaries are enrolled in the traditional Medicare program.

2 The professional standards review organizations, which preceded the peer review organizations, were charged with identifying and eliminating medically unnecessary hospitalizations and did not address quality of care.

The development of new information on the pervasiveness of quality problems has led to a change in the underlying rationale for policymakers' concerns about quality. Recent research has shown that quality problems exist across the entire health care system, under all financing and delivery arrangements and across all types of service sites. It also has shown that services that can improve patients' health and functioning are underused even when providers have financial incentives to provide them, that errors needlessly occur because of poorly designed health care processes and systems, and that many medical services are furnished that offer no benefit and that even may expose patients to unnecessary risk.³ These findings highlight the importance of systemwide, comprehensive quality assurance and improvement.

Objectives and orientation of quality assurance and improvement activities

The objectives for quality assurance in Medicare have changed over time. The philosophy underlying the establishment of Medicare's peer review organizations (PROs), originally instituted to provide retrospective case reviews of the hospital care that beneficiaries obtained, was to ensure that beneficiaries' care was at least no worse than that obtained by the rest of the population. Given this orientation, PROs were responsible for uncovering incidents of poor quality care. The Institute of Medicine and other influential groups criticized this approach and called for changing Medicare's quality initiatives from punitively focusing on outliers to improving systems and processes associated with health care delivery (Lohr 1990). Medicare since has adopted a different objective, continuous quality improvement, under which quality is regularly assessed, addressed, and reassessed. This objective is reflected in many, if not most, of Medicare's current

quality initiatives for health care providers and health plans, and is consistent with the current responsibilities of the quality improvement organizations (QIOs).⁴

The issue of whether to orient quality initiatives toward care provided to individuals or to populations is of current interest in the health policy and public health communities. Medicare's systems currently provide a blend of both, featuring individual protections and quality safeguards combined with population-based measurement and improvement initiatives. The emphasis has been on the latter, however, since the QIOs' contractual obligations changed in the early 1990s to emphasize profiling of physician practice patterns over retrospective review of individual episodes of care (Jencks and Wilensky 1992).

Medicare's role in addressing quality

Differences in Medicare's responsibilities under the traditional program and risk contracting arrangements suggest that some differences in the nature and scope of activities the program uses to safeguard and improve quality might be appropriate. Under the traditional program, Medicare performs both those functions normally associated with a health care purchaser (payment for care) and those normally undertaken by a health plan (insurance and administrative functions). By contrast, Medicare risk arrangements limit the program's role to that of health care purchaser.

Because Medicare's responsibilities under the traditional program include those of both health care purchaser and health plan, the program conceivably could employ strategies associated with both roles in its efforts to influence health care quality. To date, however, the traditional Medicare program has

adopted few of the quality assurance and improvement strategies many health plans use to influence care.

Medicare has assumed a variety of roles in its quality assurance and improvement policies but has adapted them differently in the traditional and managed care programs and across various provider types, including hospitals, physicians, skilled nursing facilities, and home health agencies. These roles include insurer of safety, or beneficiary protector; quality improvement partner; empowerer of the beneficiary, or consumer advocate; and active purchaser of health care. Quality-oriented health care management is another strategy that Medicare does not use now, but could use in the future. Historical objectives, technical constraints, and legislative restrictions have contributed to the current, significant difference in quality programs across Medicare.

Legislative restrictions constrain the extent to which Medicare can employ certain strategies and activities used by private purchasers and health plans to influence health care quality. Among those restrictions posing the greatest constraints are a prohibition on constraining beneficiary choice of providers and a prohibition on Medicare's interference in the practice of medicine, which might be interpreted to preclude a wide range of quality-based purchasing or management activities. Some Medicare policy experts have suggested that these constraints need to be revisited if traditional Medicare is to be able to compete with private health plans on quality and cost parameters (Etheredge 1998, Scanlon 1998). Absent such flexibility, Medicare will be unable to introduce many health care management and purchasing strategies that could be used to affect quality in the traditional program.

3 Chapter 3 of this report considers the issue of Medicare's role in addressing the problem of health care errors.

4 The organizations now prefer to be called quality improvement organizations because they believe this name reflects the scope and orientation of their current responsibilities better than peer review organizations, the term used in statute and by HCFA.

Establishing accountability for quality

In the Medicare+Choice program, health plans (or their sponsoring organizations) serve as Medicare’s contractors and natural units of accountability, but Medicare’s traditional program holds numerous actors accountable for the quality of care provided. At present, Medicare holds:

- individual practitioners responsible for providing appropriate care in discrete episodes,
- health care facilities responsible for meeting participation standards, and
- QIOs responsible for improving quality at the state level.

Under the Medicare+Choice program, health plans are responsible for ensuring that beneficiaries receive the care they need. No similar accountability exists under the traditional program, although it might rest in part with the beneficiary, in part with the program, and in part with the beneficiary’s primary care provider (where such a relationship has formed).

Traditional Medicare lacks some of the accountability mechanisms of Medicare’s health plan contracting arrangements. Among the most essential differences is that providers under traditional arrangements do not assume responsibility for defined populations of beneficiaries. The absence of such responsibility makes it difficult to evaluate the care delivered to a defined population. For instance, it is possible to calculate a health plan’s influenza vaccination rate by dividing the number of enrollees by the number vaccinated during a particular period of time. A similar calculation can be made for the traditional program as a whole or for any defined geographic area with a sufficient population. But because no individual physician or group of physicians is responsible for providing this service to any particular beneficiary under traditional Medicare,

the program lacks the direct accountability that exists under contracting arrangements.

On the other hand, establishing meaningful accountability under contractual arrangements with health plans can be compromised by a different type of concern. Specifically, extensive overlap among provider networks can reduce a purchaser’s ability to differentiate plans meaningfully on the quality of care they provide or other important aspects of performance. The Buyers’ Health Care Action Group, a group purchasing cooperative in Minneapolis, addressed this problem by contracting directly with networks of providers and restricting providers’ ability to participate in multiple networks. As a larger, market-driving purchaser with public responsibilities and accountability, however, Medicare would face numerous challenges in adopting such an approach.

Steps toward comprehensive quality systems in Medicare

MedPAC offers five recommendations to strengthen Medicare’s ability to provide comprehensive quality assurance to all beneficiaries, irrespective of their choice of health care financing and delivery arrangements or the providers seen. The Commission calls for the program to:

- define and prioritize goals for improving beneficiaries’ care,
- structure quality improvement efforts to be comparable and coordinated programwide,
- work with other stakeholders to ensure investment in the quality measures and health information systems needed to assess quality,
- establish positive incentives for quality improvement, and
- use quality improvement mechanisms and methods that are consistent with best practices.

Establishing programwide goals for improvement

The complexity and interrelatedness of today’s health system suggest that quality improvement goals need to be consistent at a broad, comprehensive level. Health care providers rarely work in isolation; the health system has developed increasingly complex relationships among health care providers and organizations. For example, one physician might participate in Medicare, Medicaid, and several managed-care and indemnity health plans while maintaining admitting privileges at one or more hospitals. In such a system, disparate agendas to improve quality sponsored by different payers, plans, professional organizations, facilities, and private accrediting bodies are likely to diffuse into limited relevancy. They also are likely to yield inefficient use of quality improvement resources.

At present, HCFA separately defines quality improvement priorities for QIOs and for health plans participating in Medicare+Choice. The six national priorities for quality improvement that HCFA will require QIOs to address during the current three-year contracting cycle are acute myocardial infarction, diabetes, congestive heart failure, pneumonia, stroke/transient ischemic attack/atrial fibrillation, and breast cancer. Health plans, by contrast, are required under QISMC to conduct two quality improvement projects annually, one that the plan defines to target its enrollees’ specific health care quality concerns and a national project determined by HCFA (diabetes in 1999).

By defining programwide quality improvement goals that provide a framework for selecting operational improvement goals, Medicare could benefit both from a clearer focus on issues important to beneficiaries’ care and increased programwide coordination of efforts to address those issues.

RECOMMENDATION 2A

The Secretary should define and prioritize programwide goals for improving Medicare beneficiaries' care. Examples of such goals might include minimizing preventable errors in health care delivery or increasing patients' participation in their care. These goals should be periodically identified and reassessed through a formal, public process involving all stakeholders.

At the program level, goals for improvement need to be sufficiently broad to encompass quality issues that affect beneficiary care under all payment arrangements and at all service sites. These goals can be used to define specific improvement projects for health care organizations or facilities. For example, if Medicare were to adopt reducing errors in health care delivery as a quality improvement goal, hospitals participating in Medicare might establish targets for reducing medication errors, while quality improvement organizations and health plans might focus on errors that occur in providing certain ambulatory care services.

The process used to define and prioritize goals for improving Medicare beneficiaries' care will be key in determining the success of that effort. Selecting appropriate quality improvement goals will require the program to draw on public health experts, providers, beneficiary representatives, private accreditation and quality improvement organizations, and others who can help weigh the evidence, set priorities among competing goals, and assess the potential for improvement in particular areas. To focus attention and conserve health care resources, the program also should consider how potential goals for improving beneficiary care relate to the quality improvement goals established by prominent public and private groups. Medicare's goals must be periodically revisited and revised as new data become available, new opportunities for improvement are identified, and existing goals are met.

Structuring quality improvement efforts

Medicare is one program involving numerous distinct payment systems and service sites. Separate quality systems focusing on different health objectives are unlikely to have the impact that one cohesive, coordinated system might.

RECOMMENDATION 2B

The Secretary should ensure that systems for monitoring, safeguarding, and improving the quality of Medicare beneficiaries' care are, to the extent possible, comparable under traditional Medicare and Medicare+Choice and that the systems are coordinated with each other as needed to maximize opportunities to reach quality improvement goals.

Medicare's quality systems for different health care delivery settings have evolved independently, meaning that the strategies for ensuring and improving quality and the tools for assessing progress have been only minimally coordinated. By creating uniformity in quality initiatives across payment systems and service settings, Medicare could ensure fairness for providers and comparable protections to beneficiaries under traditional Medicare and Medicare+Choice. At the same time, maintaining distinct quality assurance and improvement programs for specific types of health care (such as home health care or hospital care) ensures focused attention on the quality issues of greatest importance in those areas.

Addressing many health care quality concerns, particularly those relating to chronic disease and disability, also requires a coordinated effort that goes beyond focused service-site-specific quality initiatives. To enable QIOs to address such sophisticated improvement goals, Medicare might need to give the organizations more tools to obtain data that represent the full spectrum of care. For example, Medicare might require health care facilities and organizations participating in the program to contract with the QIOs.

Investing in tools for assessing quality

Strengthening Medicare's traditional quality program will require investments in new tools for assessing quality. Medicare needs measures of health care quality to evaluate the performance of individual health plans, the program as a whole, each type of health care financing and delivery arrangement, and the health care facilities and practitioners participating in the program. Health care organizations and providers need information systems that enable them to report on the quality of care they furnish accurately and efficiently.

Quality measures and measurement methods

The program needs quality measures that reflect the full spectrum of health care beneficiaries use. To ensure the efficient use of resources and to avoid diffusing the incentives for improvement created by measuring and reporting on particular aspects of care, the development and use of such measures must be coordinated among health care purchasers, health plans, providers, consumer representatives, and others interested in information on quality.

RECOMMENDATION 2C

The Secretary should ensure that Medicare works with other interested parties to promote the development and use of common, core sets of quality measures that represent the full spectrum of care obtained by beneficiaries.

Quality and performance measurement is a critical part of nearly every modern quality assurance and improvement effort. Measures can be used to identify opportunities for improvement, evaluate success in doing so, and compare alternative health care providers. The ability to measure quality creates a vast new array of quality improvement strategies not previously feasible.

Only within the past few years have quality measures become available to assess the care provided to the elderly and disabled Medicare population. Measures for evaluating the care provided to beneficiaries enrolled in managed care plans were developed as part of the Health Plan Employer Data and Information Set (HEDIS). One performance measure developed as part of Medicare HEDIS, the Health Outcomes Survey (HOS), represents the first global outcome measure available for assessing beneficiaries' health status.⁵ Surveys designed to assess Medicare beneficiaries' experiences in obtaining care under both managed care and fee-for-service arrangements were developed as part of the Consumer Assessment of Health Plans (CAHPS) initiative.

Some of the new tools for Medicare quality assessment, including both HEDIS and CAHPS, were developed with private-sector quality organizations, employers, and other stakeholders. Cooperative development adds to the value of the resulting products by ensuring a common purpose and approach, even though specific measures may vary because of differences in the populations, data issues, or other differences between Medicare and private-sector insurance programs. A private-sector organization now in development, the National Forum for Health Care Quality Measurement and Reporting, may provide an opportunity for HCFA to expand its work with other stakeholders to define common interests in quality measurement and to coordinate means for collecting data on quality.⁶ The Performance Measurement Coordination Council—established to coordinate the efforts of three national accreditation programs that promote use of quality measures—also might provide a vehicle for accomplishing these goals.

Limitations in quality measurement methods continue to present challenges, however. For example, to make fair comparisons among health plans or providers, risk adjusters are needed to account for differences in underlying populations. Because measures of health care outcomes are believed to be more sensitive to such differences, HCFA uses measures of health care processes to make comparisons across health plans and outcome measures to evaluate performance within a plan over time. The HOS, an exception to this rule, will be risk adjusted, although the methods used for making adjustments have yet to be worked out. Other technical problems relate to the ability to report accurate measures. HCFA's audits of HEDIS performance data reported by plans have revealed significant problems in the accuracy of reported data due to incomplete encounter data, difficulty in integrating data from various providers, errors in using quality measurement techniques, and other issues. Many such problems have been attributed to limited experience with quality measurement.

An additional issue is the uneven progress in developing quality measurement methods, with greater advances in methods applicable to managed care arrangements than with those for traditional Medicare. For example, measuring the quality of care provided in individual physicians' offices presents at least two technical challenges. The first is insufficient sample sizes to conduct reliable measurement using many existing measures. The second is defining the denominator to be used in making measurements. Under traditional Medicare, beneficiaries can see as many or as few providers as they wish and do not necessarily have a primary care physician who accepts responsibility for coordinating and managing their care.

Because reporting data on performance creates strong incentives to improve, quality measures should focus on the health care processes and outcomes that are important for beneficiaries' health and functional status. Measures to assess many important aspects of the quality of beneficiaries' care are still lacking. For example, many more measures of preventive care have been developed than for chronic care. In addition, few measures have been developed to assess the effectiveness of efforts to coordinate care across service sites. To use comparable quality systems across Medicare's delivery settings, quality measures that reflect the full spectrum of beneficiary care provided at all types of service sites must be developed and used.

Health data and information systems

Numerous types of data from various sources are used in quality measurement, including:

- administrative data, such as enrollment records or claims;
- medical data, including information from medical records and clinical laboratory reports; and
- survey data, including information on patients' satisfaction with their health care, experiences obtaining care, or health and functional status.

Although some of the data used in quality measurement are collected to serve in other administrative functions or care management efforts, accessing these data for quality measurement purposes can be challenging. Using such data can be prohibitively expensive, particularly because many types of health data, including medical records, are stored primarily in written form. For example, health plans' costs associated with HEDIS performance measurement were

5 The Health Outcomes Survey was known until recently as Health of Seniors. HCFA changed the name when it decided to expand use of the survey to include disabled beneficiaries.

6 The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry recommended developing such an organization to promote effective and efficient measurement of health care quality throughout the health system.

estimated to range from \$20,000 to \$700,000 per measure (Eddy 1998). Privacy concerns present barriers to collecting or accessing certain types of data, particularly data that are traceable to individual patients. Finally, depending on how they are structured, health care organizations and payers may not have easy access to data collected by individual providers.

Health care providers and plans need accurate and reliable information systems to collect the data used to measure health care quality. To foster accurate and efficient quality measurement, a number of steps are needed. First, a number of elements of data collection must be standardized, including elements of data sets and terminology. Second, health data systems must be automated to allow for easier transfer and use of data. Third, information collection systems need to be designed so as not to create new record keeping and paperwork burdens for physicians and other health care providers. Finally, privacy concerns must be addressed by developing appropriate encryption methods and by limiting access to data to authorized users.

Medicare is confronting these challenges as it implements quality measurement and reporting systems for health care providers and organizations participating in the program. A notable example is the Outcomes and Assessment Information Set (OASIS), developed to collect information on patient functioning and health status in the home health setting. HCFA originally planned to require submission of OASIS data by participating home health agencies beginning in April 1999 but delayed implementing this requirement until further notice because of privacy concerns.

Establishing incentives for quality improvement

Another issue Medicare must address in considering its traditional quality initiatives is the extent to which the program relies on performance incentives versus penalties for substandard

performance. Medicare's current policies include sanctions for health care organizations and providers who fail to meet minimum standards of quality and beneficiary safety but no rewards or other incentives to exceed performance expectations.

RECOMMENDATION 2D

The Congress should provide HCFA with demonstration authority to test various mechanisms—such as payment incentives, preferred provider designations, or reduced administrative oversight—for rewarding health care organizations and providers that exceed quality and performance goals to counterbalance existing penalties for substandard performance.

With the development of better tools for evaluating quality, Medicare increasingly has the ability to distinguish among poor performers, adequate performers, and exceptional performers. Until recently, establishing performance-based incentives was not possible because most of Medicare's standards for providers and organizations were structural (such as licensure or use of an internal quality assurance program), meaning the standards could either be met or not met, but not exceeded.

Under its new quality system for managed care plans participating in Medicare, HCFA will have information to distinguish among the levels of performance and health care quality its contractors provide. The agency expects to define a floor level of performance by designating minimum quality standards that plans must meet or risk contract renewal. Conceivably, however, HCFA also could establish benchmarks of performance and incentives for plans to attain those levels. Possible incentives could include designating excellent plans in comparative materials provided to help beneficiaries make enrollment decisions, differentiating beneficiary premiums to steer enrollment toward better plans, or linking Medicare payments to the health plans to quality

findings through a performance-based payment system. The program also might find a way to relieve exceptional performers from some of the burden of demonstrating compliance with the program's rules, perhaps by reducing the frequency of compliance reviews.

Performance incentives also might be established in the traditional program to reward exceptional performance. Certain sectors of the health care delivery system have quality measurement systems that might be developed for use in this manner, but limitations in the ability to assess and compare quality routinely in most sectors, including hospitals and individual physicians' offices, limit widespread implementation in the short term.

Using strategies that are consistent with best practices

Although differences in the nature or extent of Medicare's quality assurance and improvement activities under the traditional program and Medicare+Choice could appropriately reflect the differences in Medicare's responsibilities under those programs, all of Medicare's quality-related activities should be consistent with best practices.

RECOMMENDATION 2E

The Secretary should ensure that the methods and mechanisms used to influence quality under traditional Medicare are consistent with best practices used by private health plans and purchasers.

As one of the largest purchasers of health care, Medicare has considerable influence over the industry, and the strategies and activities relating to quality that it adopts affect providers, plans, and consumers nationwide. Therefore, decisions about where to focus Medicare's resources and attention, in terms of quality assurance and improvement strategies, determine directions for the industry and affect all health care consumers.

Unfortunately, little is known about which quality assurance and improvement activities have a demonstrable and substantial impact on the quality of care. Carefully designed research initiatives and demonstrations of alternatives are needed to obtain and assess data on the effectiveness of these activities. Relevant information on the relative effectiveness of quality improvement activities may be forthcoming. The Agency for Health Care Policy and Research plans to award up to \$2 million in fiscal year 1999 to support as many as five studies to evaluate strategies for improving health care quality—such as continuous quality improvement, use of regulations, behavioral interventions, and educational interventions—that are now widely used by organized quality improvement systems. Pending better information, Medicare should take steps to ensure that its quality initiatives are both consistent and coordinated with the practices of other influential purchasers and plans to avoid sending mixed signals to the health system without due cause.

Strengthening quality systems in traditional Medicare

Medicare, like other purchasers and health plans, employs a variety of strategies to influence quality. At present, the strategies used for traditional care arrangements differ substantially from those used for managed care. Medicare's quality activities also differ from those of private purchasers and plans that have been recognized for leadership, particularly in that the program has to date made limited use of quality-based purchasing and quality-oriented management techniques.

Ensurer of safety/beneficiary protector

The role that characterizes the preponderance of Medicare's past and current quality-related activities is that of

ensurer of beneficiary safety. In this capacity, the program has established ground rules for health care providers and plans that serve beneficiaries, systems for addressing grievances and appeals, and a quality-policing function. The roles of private-sector purchasers and plans have evolved somewhat differently.

Medicare's conditions of participation

Ground rules for serving Medicare beneficiaries, known as conditions of participation (COPs), vary considerably by type of health care provider or organization. At present, any provider or organization that meets HCFA's ground rules is eligible to participate in the program unless specifically excluded, a process that normally occurs only when egregious violations have been found and following an administrative procedure that provides due-process protections for the provider in question.

Many of Medicare's participation requirements were established to serve as proxies for quality or to otherwise serve as consumer protections because—until quite recently—few tools were available to assess the quality of health care beneficiaries receive and little was known about techniques for influencing that care. Perhaps the best example of such a requirement is Medicare's so-called 50-50 rule for participating health plans, which capped enrollment of publicly insured (Medicare and Medicaid) beneficiaries at 50 percent of a plan's total enrollment. Many program stakeholders found this requirement to be of questionable value as a quality proxy. Judging it to be obsolete with the development and use of better quality-assessment mechanisms, the Congress eliminated the 50-50 rule under the Balanced Budget Act of 1997 (BBA).

The net effect of Medicare's COPs, including those designed as consumer and patient protections or to serve as safeguards against quality problems, has been to establish a floor or baseline of minimum quality. In the past, this floor was largely determined by adherence to

minimum structural requirements, such as licensure and maintenance of an internal quality improvement system. Such requirements are sometimes questioned, however, because the relationship between structural features and patient outcomes has not been adequately studied. For most providers, including physicians and hospitals, structural requirements still determine the floor. With the implementation of new Medicare+Choice requirements, however, HCFA expects to base the floor for health plans partly on objective assessments of actual performance.

Medicare presently uses different approaches to monitor providers' and plans' compliance with program requirements. Health care facilities demonstrate their compliance with COPs by obtaining either accreditation from an approved private-sector entity or certification from a state agency that has a contractual relationship with HCFA. HCFA now monitors Medicare+Choice plans' compliance with program requirements through site visits conducted by agency personnel, although private accreditation is likely to play a role in health plan monitoring in the future. The BBA authorized the agency to accept private accreditation by approved entities in place of direct oversight for some, but not all, of the quality-related requirements established in legislation. HCFA will define a process for assessing which accrediting bodies have standards and review mechanisms that are at least as stringent as Medicare's.

Accreditation and credentialing in the private sector

Accreditation and credentialing standards serve as private-sector analogs to Medicare's COPs. These standards do not always serve as floors, however. In some cases, accreditation is designed to distinguish top performers.

A growing number of large purchasers require the plans they contract with to attain accreditation from a private standard-setting body, although most purchasers as yet do not (Gabel et al.

1998). Medicare's COPs tend to lag private accreditation standards, in part due to infrequent updating of the COPs and the extensive public comment process required under Medicare. For example, HCFA's COPs for hospitals, last updated in 1986, do not require hospitals to measure and report to HCFA on the quality of care they furnish. The predominant hospital accrediting body, the Joint Commission on Accreditation of Healthcare Organizations, on the other hand, has recently added such requirements. A notable exception to this rule of lagging the private sector occurred with the introduction of QISM standards for health plans participating in Medicare, in which Medicare went beyond private-sector standards established by the National Committee for Quality Assurance by requiring that plans demonstrate actual quality improvement.

Credentialing programs are used by health care facilities and health plans to check practitioners' qualifications and background against defined structural requirements (such as board certification). Although these programs do not currently include measures of health care quality, the American Medical Association (AMA), through its American Medical Accreditation Program, is defining measures that could be used in a national program designed to replace multiple duplicative credentialing programs. In this effort, the AMA is working closely with the specialty societies and other groups that are defining appropriate performance measures for medical professionals.

Systems for grievances and appeals

Medicare's systems for addressing beneficiary grievances and appeals differ for managed care and the traditional program. For managed care enrollees, Medicare's systems constitute an external process that supersedes the internal

processes plans have for resolving coverage concerns and other types of complaints. For beneficiaries in the traditional program, Medicare's systems are the first venue for addressing beneficiaries' concerns about the program or its providers.⁷ Medicare's quality improvement organizations provide a forum for investigating beneficiary complaints about the quality of their care.

Use of grievances and appeals systems varies considerably in the private sector. Nearly all plans offer internal grievance and appeals processes to resolve members' complaints and to provide an outlet for reconsidering coverage or payment decisions. However, as ongoing debate over the potential enactment of a patients' bill of rights demonstrates, there is by no means universal agreement on the need for a binding external system for appealing coverage decisions.

Quality policing

Medicare has scaled back its role in actively seeking and redressing individual instances of substandard care. This function was historically delegated to peer review organizations, state-based groups of medical professionals, quality experts, and statisticians. Until recently, these organizations served primarily as case reviewers, investigating individual instances of hospital care suspected to be substandard, and levying financial penalties or, in certain cases, beginning a process of program exclusion. With the significant changes in these organizations' functions that HCFA has gradually implemented over the past six years, their responsibilities for case review have greatly diminished. At present, HCFA estimates that each QIO initiates approximately four inquiries a year to follow up on investigations that have yielded evidence of serious violations, and that about one case per QIO per year results in provider exclusion, fines, or other sanctions.⁸

Although private-sector purchasers do not normally adopt a quality-policing role per se, health plans do so in the form of prior authorization and utilization review programs. These programs are generally set up internally or under contractual arrangements to provide a check on providers' decisions about appropriateness of services or referrals to specialists.

Quality improvement partner

The idea of collaborative activities geared toward quality improvement is relatively new to both Medicare and the private sector.

Plans' and purchasers' collaborative quality improvement activities

Health plans often work with network providers to improve quality by developing and disseminating practice guidelines, conducting provider profiling and feedback, and sponsoring educational programs (Gold et al. 1995). Use of such activities is more extensive in the more tightly structured plans. Also, these efforts may be focused more or less on quality concerns than cost control.

Some private purchasers have also developed collaborative relationships with their contractors in efforts to improve quality. Xerox, for example, instituted an active health benefits management program several years ago, in which the company developed long-term contracts with plans and worked with them to define concrete goals and activities for improving employees' health. This type of activity is now being carried out by only a small group of large employers and purchasing cooperatives, however.

7 Beneficiaries can apply to an administrative law judge to appeal coverage decisions made by Medicare's carriers or fiscal intermediaries.

8 Provider groups and others have raised concerns that the new payment error prevention program—which requires QIOs to address unnecessary hospital admissions and miscoding—could instigate a return to adversarial relations between providers and QIOs. HCFA, however, states that the program will emphasize correction of mistakes and education of the provider community rather than investigation of fraud.

Medicare's quality improvement partnerships

Medicare's recent steps to become a quality improvement partner are best represented by the change in responsibilities of Medicare's state-based contractors for external quality assurance (Jencks and Wilensky 1992). In contrast to the former PROs, which reviewed individual cases and made retrospective assessments of quality problems, QIOs undertake focused quality improvement activities, provider profiling, and educational activities in conjunction with local providers.

Up until the contractual cycle beginning this year, each of Medicare's QIOs developed and implemented its own quality improvement projects individually, operating under the notion that the organizations were best situated to work with local providers to identify specific quality concerns. Under the new arrangements, HCFA establishes national quality improvement projects, and QIOs are under contractual obligation to demonstrate quality improvement at the state level in beneficiary health and functional areas defined by HCFA.

The role of the QIOs in evaluating the care provided in individual physicians' offices and through managed care plans participating in Medicare is still evolving.⁹ Traditionally, the organizations developed contractual relationships with hospitals that enabled them to obtain information from medical records and to keep information confidentially without concerns about plaintiffs' attorneys when malpractice suits might be pending. Entering into such relationships is, and has always been, voluntary, however. Under QISMC, managed care plans have incentives to work with QIOs on national quality improvement projects because they can save much of the cost of developing quality measures and defining data requirements independently. Proposed new conditions of participation for hospitals would create similar

incentives. Individual physicians can volunteer to participate in practice profiling and other projects to improve the quality of ambulatory care.

Although available studies do not use uniformly rigorous methodology, they suggest that the QIOs' collaborative projects have resulted in measurable quality improvement. In a study of the results of the contractors' efforts under the 1996-1999 contracting cycle, HCFA found that 87 percent of the projects for which final results were available had improved quality by at least one measure (HCFA 1998). The significance of those findings is difficult to characterize, however, since each project used different improvement objectives, interventions, and quality measures. Results from the pilot project to test the QIOs' first national improvement project, which targeted heart attack care in four states, showed improvement across all quality indicators studied, with aspirin use increased from 84 percent to 90 percent and beta-blocker use increased from 47 percent to 68 percent, for example (Marciniak et al. 1998).

Quality-oriented health care management

As part of efforts designed to affect costs and/or quality, private health plans sometimes use tools such as disease management, in which patients with certain chronic illnesses are given special attention through particular monitoring, measurement, and care management activities; and case management, in which unusual or outlier cases receive monitoring and active intervention by an assigned manager who is sometimes authorized to work outside normal plan coverage or network parameters.

Research now getting under way is likely to shed some light on the extent to which these programs contribute to improved health outcomes or costs savings. A three-year study cosponsored by the Agency for Health Care Policy and Research and

the National Institutes of Health represents the first randomized controlled trial comparing costs and patient outcomes for asthma patients in a disease management program to those for patients obtaining usual care.

In its efforts to improve quality under the traditional program, Medicare does not now use many of the tools available to private health plans for managing care, although the program has taken steps to prepare for future use. The BBA required HCFA to test and evaluate the use of case management and other models of coordinated care to improve the quality of care for chronically ill beneficiaries enrolled in traditional Medicare and to reduce program spending. Demonstrations are to be conducted in at least nine sites. Under a contract with Mathematica Policy Research, Inc., HCFA is now identifying best practices for coordinating care in the private sector and plans to assess the extent to which such programs could be used under traditional Medicare. In the BBA, the Congress also authorized the Secretary to expand the demonstration and to implement components of the projects into Medicare permanently, based on evaluation findings. The BBA also provided for coverage of diabetes self-management training services under Medicare. This coverage addition offers an opportunity for evaluating the utility of such coverage for a specific population with chronic illness.

Accounting for quality in purchasing and payment arrangements

Without changes in law, limits on HCFA's ability to act as a prudent purchaser of health care will constrain efforts to influence quality under traditional Medicare although, under demonstration authority, the program may have opportunities to test active purchasing approaches that it could not otherwise implement.

9 End Stage Renal Disease (ESRD) Networks—which promote continuous improvement in the quality of renal dialysis care and undertake other tasks relating to ESRD program administration—serve in a role similar to that of the QIOs. See Chapter 8 for an analysis of ESRD quality issues.

Private sector use of quality-based purchasing activities

As yet, remarkably few private-sector purchasers use purchasing strategies to improve the quality of care they buy. A 1997 study by the General Accounting Office showed that although large purchasers now commonly request data from plans to document the quality of care, few purchasers incorporate such information into their contracting decisions or payment arrangements.

A few notable exceptions serve as models for quality-based purchasing initiatives that Medicare might consider in the future, however. For example, the Pacific Business Group on Health adjusts payments to plans based on their performance in providing preventive care. The Leapfrog Group, a coalition of purchasers concerned with improving health care quality, is developing selective contracting strategies designed to steer patients to certain service providers, drawing on research that shows a high correlation between volume and outcomes of certain services.

While no rigorous evidence of the effects of prudent purchasing strategies on quality has been developed, some research suggests that purchasers who use those strategies believe them to be beneficial. In a recent study of four large health care purchasers that use quality-related information (such as accreditation reports, quality measures, and satisfaction survey results) in making their purchasing and payment decisions, the General Accounting Office found that the purchasers associated those activities with improvements in access to care and employee satisfaction, as well as with cost savings (GAO 1998).

Health plans also have opportunities to act as quality-based purchasers, particularly by considering performance in defining and refining provider networks. However, most of the limited research on plans' contractual

arrangements with providers suggests that market pressures that reward plans with large or loose networks, combined with cost constraints, still play predominant roles in defining networks (Gold et al. 1995, Hurley et al. 1996).

Quality-based purchasing by Medicare

Use of quality-based purchasing activities is now quite limited in Medicare. Other than requiring conditions of participation, such as licensure, to be met, HCFA has not traditionally incorporated information about health care quality and performance into its decisions about which health plans and providers can participate in the Medicare program. The agency also has not tried to differentiate plans or providers on the basis of their demonstrated quality or performance in making purchasing or payment decisions. Before initiating QISMC, HCFA also had not provided incentives for health care providers or health plans either to improve the quality of care they furnish or to meet minimum performance levels. In fact, the agency has been criticized for failing to take sufficient action against health plans that failed to fulfill the terms of their contracts (GAO 1995, GAO 1991a, GAO 1988) and against hospitals consistently found to be out of compliance with conditions of participation (GAO 1991b).

Most of HCFA's prudent purchasing initiatives focus on the managed care program, under which the agency faces fewer legislative constraints. For example, the program's new quality improvement system for managed care requires coordinated care plans participating in Medicare+Choice to demonstrate that they improve quality and meet minimum levels of quality as shown by defined performance measures. Plans that fail to do so risk exclusion from the program. Medicare's competitive pricing demonstration, which is testing the effects of allowing health plans to influence payment rates through

bidding, also provides a way for Medicare to test use of quality-based purchasing techniques under managed care. HCFA's demonstration advisory committee recommended that the agency consider withholding a small percentage of savings obtained as a result of the competitive bidding process, to be distributed among participating plans based on how well they achieve quality goals.

The Centers of Excellence demonstration represents Medicare's closest approximation of a preferred provider arrangement under the traditional program. Under the demonstration, HCFA contracts with a group of cardiovascular and orthopedic facilities to provide certain cardiovascular services or total joint replacement procedures under bundled payment arrangements. Hospitals compete to participate in the demonstration based on quality (defined primarily by volume of services provided), organizational capability, price, and geographic dispersion. Selected hospitals are designated as Centers of Excellence and are allowed to offer lower cost sharing, simplified claims processing, and lodging support as a means of attracting patients. Earlier experience with similar demonstrations for coronary artery bypass graft (CABG) and outpatient cataract surgical procedures showed opportunities for the program to achieve savings, if not quality improvements.¹⁰

HCFA's competitive pricing demonstration for durable medical equipment (DME) may provide information on Medicare's ability to be a price- and quality-conscious purchaser in the traditional program. Under the demonstration project, DME suppliers' bids will be evaluated based on the prices they will accept and evidence of the quality of their products. Losing bidders will be excluded from supplying DME to Medicare patients in the geographic areas included in the evaluation.

10 The CABG demonstration achieved an estimated savings of nearly \$40 million for Medicare over 10,000 CABGs performed at seven sites. The cataract surgery demonstration, implemented at four sites in three cities, was estimated to save Medicare more than \$500,000 for some 7,000 surgeries.

Consumer empowerment

Medicare needs to take steps to advance beneficiaries' ability to make quality-based decisions when choosing among health care providers. Although HCFA is taking steps to help beneficiaries choose between the traditional program and plans available under Medicare+Choice, similar efforts need to be extended to help beneficiaries choose among health care facilities and practitioners.¹¹

RECOMMENDATION 2F

The Secretary should develop and disseminate consumer-oriented information on quality of care to help beneficiaries compare enrollment options and providers. This information should include geographic area-specific information on the quality of care furnished to beneficiaries enrolled in traditional Medicare and provider-specific information on the quality of care furnished by health care facilities and practitioners participating in the program.

Purchasers' and plans' efforts to empower health care consumers

Employers and other purchasers who offer more than one health plan typically provide information to assist in health care choices but, as yet, they rarely include information designed to yield quality-based choices. One notable exception is the Federal Employees Health Benefits Plan, which was one of the first large purchasers to collect and analyze consumer satisfaction data for employee use in selecting plans. Xerox and GTE were also among the early pioneers in giving employees information on health care quality, providing report cards that include HEDIS performance measures and results of consumer satisfaction surveys.

With rare exceptions, health plans do little to help their enrollees make quality-based decisions about which providers to choose. One such exception is Aetna

U.S. Health Care, which grades its primary care providers along dimensions such as patient satisfaction and adherence to plan standards, then provides those grades to interested enrollees. Similarly, PacificCare gave its members a quality and consumer satisfaction report card based on profiles of its participating physician groups. The health plan recently reported that members used those data in choosing a group to enroll with. Each of the groups scoring above the 32nd percentile gained members, while groups at the 25th percentile or below lost members (Medicine and Health Daily 3/11/99).

Medicare's consumer empowerment efforts

Although HCFA has traditionally provided for a number of activities—such as regulating health plan marketing materials and establishing processes and forums for resolving complaints and for making appeals of coverage and treatment decisions—that serve the beneficiary as a health care consumer, the program has not until recently played a significant role in helping beneficiaries to consider health care quality in deciding where and how to obtain services.

The most notable historical exception to this is the program's controversial experience in releasing hospital mortality data. Medicare published data on hospitals' mortality rates from 1986 until 1992, when it responded to concerns about data accuracy and adequacy of case-mix adjusters by ceasing to collect and report the data. One study showed that HCFA's release of patient mortality rates at individual hospitals had only a small effect on hospital use (Mennemeyer et al. 1997). For instance, patient discharges at one hospital with a death rate double that expected by HCFA dropped by less than one per week in the first year following publication of that rate. However, the underlying reasons for the lack of impact, such as insufficient

consumer awareness or a discounting of the findings by providers, are unclear. By contrast, a study of the effects of releasing data on cardiac surgery outcomes in New York State from 1990 to 1993 found that hospitals and surgeons with better outcomes experienced higher rates of growth in market share. Researchers attributed that growth to use of the information both by patients and referring physicians (Mukamel and Mushlin 1998).

The BBA expanded HCFA's role in beneficiary empowerment considerably by requiring the agency to give beneficiaries information to use in choosing among traditional Medicare and Medicare+Choice plans, including information designed to help beneficiaries judge quality of care.¹² Directly providing for informed beneficiary choice is a new responsibility, however. HCFA has already established a "Medicare Compare" site on the World Wide Web that offers basic comparative information on the Medicare program, managed care options, and individual plans available. The Web site also has some data on health care quality from consumer surveys and performance measurement initiatives. Beginning with the full national information campaign in the fall of 1999, HCFA will mail such information to all beneficiaries and will operate a toll-free telephone information line to answer beneficiaries' questions. The agency is also working with national and local consumer advocacy groups to provide additional beneficiary assistance.

Types of information needed by Medicare beneficiaries

For beneficiaries to become informed health care consumers, two types of information are needed:

- geographic area-specific information on the quality of care obtained by traditional Medicare enrollees (to help beneficiaries compare enrollment options), and

11 See Chapter 4 for MedPAC's recommendations for structuring and fostering informed beneficiary decisionmaking under Medicare+Choice.

12 The National Medicare Education Program is described and assessed in Chapter 4 of this report.

- information on the quality of care provided at specific facilities and by individual practitioners or groups of practitioners (to help beneficiaries choose providers).

In order to use information on quality in their health care decisions, beneficiaries must have information that they believe is relevant to the level of choice they face. Medicare is now developing comparative information on the quality of care provided through coordinated

care plans, and it is in the process of testing its ability to develop comparable information on quality of care under the traditional program, as required by the BBA. Under a contract with Health Economics Research, Inc., Medicare is evaluating whether reliable information can be generated by using HEDIS measures and the Health Outcomes Survey at the national, local, and physician group-practice level. The contractors' first annual report on the study's progress suggests that numerous

technical constraints—notably problems with populations too small for analysis—make many measures unreliable at the physician group-practice level and even at the local level (the two levels likely to be of greatest interest to beneficiaries) (McCall et al. 1998). However, national data on quality under Medicare may not be sufficiently compelling to factor into beneficiaries' enrollment decisions. ■

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