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ASSESSING QUALITY IN MANAGED CARE: HEALTH PLAN REPORTING OF HEDIS PERFORMANCE MEASURES

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Although the voluntary reporting system currently in place to assess and compare the quality of care provided by health plans continues to improve, it is still limited in the role it plays in providing information to purchasers and consumers.

Quality Compass, a collaborative effort between private and public purchasers and the managed care industry directed by the National Committee for Quality Assurance (NCQA), has succeeded in laying the foundation for a national quality reporting system based on performance data obtained from the Health Plan Employer Data and Information Set (HEDIS) and the Member Satisfaction Survey (MSS). However, with just one-third of all health plans choosing to report on HEDIS measures to Quality Compass, policymakers may need to evaluate other approaches to improving participation, including encouraging purchasers to require reporting of HEDIS data to NCQA.

The following analysis examines health plan reporting patterns for HEDIS measures to identify which factors contribute to plan participation in Quality Compass and how the present system could be improved. (For a more thorough analysis of this topic, see Donna O. Farley, Elizabeth A. McGlynn, and David Klein, *Health Plan Reporting Patterns for HEDIS Performance Measures,* Santa Monica, CA: The RAND Corporation, June 1998.)

Health Plan Participation in Quality Compass

HEDIS has contributed substantially to creating a framework for producing information about quality in managed care, especially in establishing rules for collecting and reporting data that ensure comparability of results. A review of health plan reporting rates, furthermore, shows that significant strides are being made: in 1997, 35.5 percent of plans reported Quality Compass data for either HEDIS performance measures or the MSS—a barometer of patient satisfaction with the quality of managed care—compared with 28.3 percent in 1996. This still means, however, that nearly 65 percent of plans did not participate in Quality Compass at all.

Approximately 33 percent of plans reported performance measures and 22 percent reported MSS results. These percentages increase when measured by total health plan enrollment: health plans with 56 percent of total enrollment reported performance measures, and plans with 41 percent of enrollment reported MSS results.

The average enrollment of plans reporting HEDIS data is about twice that of nonparticipating plans, partly because larger plans can spread the cost of reporting across more enrollees. The generally better information systems of large plans may also help keep down the marginal costs of participation. In addition, these plans may be more inclined

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to contract with purchasers that require HEDIS as a condition of participation.

Certain types of plans are also more likely than others to report performance data to Quality Compass, with the largest differences related to product lines and model types (see Table 1). These include plans offering point-of-service (POS) options, which have been designed as a competitive response to consumer concerns about the limitations on choice found in standard managed care arrangements. Their higher participation rates suggest that plans in more competitive environments have a more urgent need to produce comprehensive quality data in order to survive.

When compared with independent practice associations (IPAs), which represent

What Are HEDIS and Quality Compass?

HEDIS—the Health Plan Employer Data and Information Set—was launched in the early 1980s as a joint effort by private purchasers and the managed care industry to develop a standardized set of performance measures that would generate comparative information for purchasers and consumers trying to choose among competing managed care plans. As the system has evolved, the collaboration has expanded to include public purchasers (Medicare, Medicaid, and the State Child Health Insurance Program), consumer representatives, and quality measurement methodologists. In 1997, the Member Satisfaction Survey (MSS) was added to the information collected in order to measure beneficiaries' satisfaction with the quality of care provided by their plans; the MSS will soon be replaced by the Consumer Assessment of Health Plans (CAHPS).

Health plans can voluntarily report HEDIS data, including MSS results, to the National Committee for Quality Assurance (NCQA), a private, nonprofit organization providing accreditation to managed care plans. The NCQA in turn makes plan performance and accreditation information publicly available through its Quality Compass, a database on CD-ROM. HEDIS 3.0, the latest version, contains eight categories of quality measures:

- effectiveness of care, including the proportion of adult women receiving a Pap smear and the proportion of children who are up-to-date with their immunizations;
- availability and accessibility of care to providers such as primary and mental health care physicians;
- satisfaction with the experience of care;
- use of services;
- health plan stability, including disenrollment rates and physician turnover rates;
- costs of care;
- informed health care choices, including new member orientation and education and language translation services; and
- health plan descriptive information.

For reporting performance on each of the measures, plans obtain information from three major sources: administrative data, including claims and encounter data and enrollment files; medical records; and member surveys conducted by outside vendors. Increasingly, private and public purchasers are requiring managed care plans to collect HEDIS data as a condition of participation.

Table 1
Provision of HEDIS 3.0 Information by Health Plans, by Plan Characteristic

	Percentage by Characteristic	Percentage Participating		
		Performance Measures	Member Satisfaction Survey	One or the Other Category
All health plans (N=781)	100.0%	32.5%	22.2%	35.5%
Percentage of enrollment		56.3	41.3	58.1
Ownership:				
For-profit	68.4	29.4	16.9	31.5
Not-for-profit	25.9	31.2	28.7	34.7
Missing	5.8	66.7	55.6	86.7
Offer other plan options				
Point-of-service:				
Yes	29.6	47.2	26.0	49.4
No	70.4	26.4	20.6	29.6
PPO:				
Yes	31.1	44.0	23.9	45.7
No	55.3	34.0	26.6	38.4
Missing	13.6	0.0	0.0	0.0
Medical contract model				
IPA	51.1	23.8	16.8	26.1
Network	9.5	21.6	24.3	28.4
Group	5.5	44.2	32.6	44.2
Staff	3.1	16.7	16.7	20.8
Mixed	29.7	51.7	30.2	55.2
Missing	1.2	0.0	0.0	0.0
Time in business				
0-5 years	25.4	10.6	5.6	11.6
6-10 years	35.7	31.6	21.9	34.8
11-15 years	15.7	42.3	31.7	46.3
More than 15 years	18.6	46.2	29.7	46.9
Missing	4.6	63.9	52.8	88.9
Total enrollment size				
15,000 or less	19.0	19.6	12.8	21.0
15,001-40,000	20.6	31.7	23.0	36.0
40,001-100,000	18.8	45.6	27.2	46.9
100,001-200,000	11.3	56.8	40.9	56.8
More than 200,000	9.2	62.5	38.9	65.3
Missing	21.1	7.3	7.9	13.3
Location by region				
New England	6.3	42.9	38.8	42.9
Middle Atlantic	12.3	39.6	31.3	44.8
South Atlantic	19.6	37.9	17.0	38.6
East North Central	19.0	27.0	21.6	31.7
East South Central	5.8	15.6	11.1	20.0
West North Central	7.8	29.5	18.0	29.5
West South Central	9.2	37.5	18.1	38.9
Mountain	9.9	26.0	19.5	29.9
Pacific	9.9	32.5	24.7	33.8

being collected using a variety of other patient satisfaction survey instruments. Changing survey instruments may disrupt the ability of health plans to gather valuable information on long-term trends. Finally, NCQA's stipulation that outside vendors be used to administer the MSS may force plans—many of which have been conducting surveys using their own staff—to reconfigure their budgets to incorporate these costs, which may require a longer lead time.

Should the Monitoring System Be Changed?

The performance standards contained in HEDIS 3.0 reflect considerable consensus among the key stakeholders in the system as to which information should be included and which methods for collecting data should be used to ensure that results are comparable. With new and better measures replacing old ones each year, the system is designed for continuous improvement. Health plans currently participating in Quality Compass have also invested significant resources in developing information systems, software programs, and a pool of experienced individuals to collect, analyze, and report the data. Retooling for a new system would take time and resources and would not necessarily produce better information. In addition, private and public purchasers have increasingly begun to require HEDIS data and NCQA accreditation as a condition of participation.

In all likelihood, many more plans collect HEDIS data than report the results to Quality Compass. In fact, some 40 plans report their results to NCQA but do not permit them to be included in the Quality Compass reports. If health care purchasers required not only that plans collect HEDIS data but that they make the results publicly available, the prospects of developing a national system of quality reporting for managed care plans would be greatly enhanced.

Conclusion

A national system for monitoring the quality of care delivered in the United States is critically important to ensuring that concerns about cost and quality receive equal attention from policymakers, purchasers, and consumers. Although the Quality Compass data represent an important step toward that goal, improvements in rates of reporting will be essential for the system to reach its full potential. Until then, Quality Compass-based conclusions on the performance of managed care must take into account the fact that all plans are not represented.

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