

Sizing up HEDIS: Experts Take System's Measure

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by Gina Rollins

NCQA's performance measurement system is well established in the industry. But is it really addressing the questions that matter? In this article, industry experts discuss how HEDIS has made its mark.

The managed care industry and large employers have embraced the Health Plan Employer Data and Information Set (HEDIS) since its introduction 10 years ago. They generally view it as a robust, consistent measure of quality and a means of reliably comparing the performance of health plans.

But the performance measurement system used by the Washington, DC-based National Committee for Quality Assurance (NCQA) to accredit health plans is not without detractors. Health plans and providers alike decry its data collection procedures, and some argue that it does not address core aspects of quality, substituting process measures for true clinical outcomes assessments.

Still, HEDIS has made its mark, influencing prevention and intervention strategies and ultimately making a difference in the lives of patients. And its greatest impact may be yet to come. This article takes a measure of HEDIS's effectiveness and explores what the next steps may be for the system.

The Goal: Better Information about Health Plans

NCQA defines HEDIS as “a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans.” HEDIS assesses health plan performance in several broad areas, including the effectiveness of care, access and availability of services, patient satisfaction, health plan stability, utilization, informed choices, and health plan descriptive information.

The 60 measures reported in 2001 covered everything from controlling high blood pressure and the availability of language interpretation services to practitioner turnover, inpatient utilization rates, and the average number of well-child visits in the first 15 months of life.

According to NCQA, in 2000, about 90 percent of all commercial health maintenance organizations (HMOs) and point-of-service (POS) health plans used HEDIS data in some way to monitor performance. However, only 372 health plans (about 65 percent) reported data to NCQA, and only 273 health plans (an estimated 50 percent) made the data available publicly so that it was included in NCQA's annual Quality Compass, a comprehensive database of HEDIS results.

A Consistent Benchmark

For health plans, HEDIS has value as both a marketing and performance improvement instrument. They report HEDIS data to employers, during both initial contract negotiations and “open season” periods when employees may switch health plans. They also make available to consumers overall NCQA accreditation reports, which typically do not include HEDIS-specific results. (HEDIS scores account for a little more than 25 percent of the NCQA accreditation formula and will carry more weight in the future, according to Brian Schilling, director of communications at NCQA.)

Health plans and employers alike tend to view HEDIS as a valuable factor in demonstrating performance and making informed healthcare purchasing decisions, primarily because of its data integrity. “Right now, nationally, it's the only benchmark we have for which there are consistent specifications and external audit of our data systems so that we can make equivalent

comparisons,” says Janice Rashed, MPH, director of measurement and analysis for Group Health Cooperative, a managed care organization located in Seattle.

“Our members see it as a way to gauge performance of health plans that they can trust,” agrees David Hopkins, PhD, director of health information improvement at San Francisco-based Pacific Business Group on Health (PBGH), a coalition of 44 employers in California that provide health coverage for about 3 million people.

Providers, however, may have a more cynical view of the role of HEDIS in health plan purchasing. “The only factor that influences the selection of health plans is cost,” contends Wells Shoemaker, MD, medical director of Physicians Medical Group in Santa Cruz, CA.

Health plans also use HEDIS to improve performance vis-à-vis customer service and the health of their members. For example, in 2001, industry giant Aetna achieved an overall HEDIS score between 53 and 54 percent for controlling high blood pressure, which is slightly above the nationwide average of 51.5 percent, according to Samuel W. Warburton, MD, national medical director for quality management. “That measure was added two years ago, and no health plan performed well, but we didn’t think it was anything to be proud of,” he explains.

Displeased with the results, the company launched a campaign to educate both members and providers about the importance of controlling blood pressure. Last fall, it mailed educational materials to 260,000 members with hypertension, including wallet cards to record blood pressure and cholesterol numbers. At the same time, it sent a one-page summary to affiliated physicians outlining the latest evidence about managing high blood pressure. These efforts are expected to improve HEDIS scores in coming years, but more importantly will also mean better health for the affected members, according to Warburton.

As it becomes more and more an industry standard, HEDIS is also increasingly being used to reward performance, for both health plans and providers. For several years, a group of PGBH employers that negotiate together with California health plans has subjected a portion of its annual premium payments to risk. If the plans meet the group’s performance criteria (which includes HEDIS data), they receive an incentive premium; if they do not, employers receive a premium rebate. So far, the system has worked mainly to the advantage of PGBH members. “Few health plans meet all the criteria. The employers get rebates from almost all, but they’d rather see more quality than have the rebate,” says Hopkins.

As their feet are held to the fire, health plans are beginning to do likewise to providers. “In the old days, health plans just used physician profiling with cost and utilization data to incentivize doctors,” explains Catherine McCabe, vice president of MEDSTAT, a healthcare information company located in Ann Arbor, MI. “But now their reward programs are more and more balanced toward quality measures, as they become more concerned with influencing behavior overall rather than just measuring it.”

The practice is not yet widespread, however, largely due to the sampling method used in HEDIS data collection. The sample of patients for some physicians is so small that it is not valid for making incentive payments.

Regardless of their other uses, HEDIS and NCQA accreditation are less and less a matter of choice for health plans. At least 22 states now mandate one or the other in some way, and large employers in particular consider both as conditions of contract. “HEDIS is not an optional exercise. Not only is it required by state law in a number of states, but from a national account perspective, there’s not a single one that does not expect us to be accredited and have acceptable HEDIS scores,” says Aetna’s Warburton.

As well, the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) requires HEDIS reporting of all Medicare managed care plans; requirements for Medicaid managed care plans vary state by state.

Raising the Performance Bar

Whether it is because of legal requirements, financial incentives, competition, or the desire to do better by members, HEDIS appears to be raising the health plan performance bar.

In its fifth annual *State of Managed Care Quality* report, which was released in September 2001, NCQA reported that for the second consecutive year, national averages for almost every measure of clinical care improved. Measures in existence longer showed lower incremental increases. For example, one long-standing measure, the average rate of breast cancer

screening, increased by just 1.1 percent in 2001, to 74.5 percent. By contrast, the average rate of cholesterol control in members with evidence of coronary heart disease, which was added in 1999, rose by 8.2 percent in 2001, to 53.4 percent.

The gap between the lowest and highest performing plans also appears to be closing. For example, in 1996, top-performing plans reported prescribing beta blockers for heart attack patients about 88 percent of the time; bottom performers did so only 37 percent of the time. But in 2001, even the 10 percent lowest performing plans administered beta blockers to 76 percent of all patients, a rate higher than the overall average five years ago.

Measuring Quality or Processes?

As noteworthy as these findings may be, they do not earn universal praise. HEDIS effectiveness of care measures—though not without merit—do not fundamentally address healthcare quality, contends Shoemaker of Physician's Medical Group.

"It's a stretch to say some really measure quality," Shoemaker says. "You can make inferences that a physician who has high childhood immunization rates has had a lot of contact with his patients and gives a lot of education about things like lead poisoning and car seat safety, for example. It's more like a marker for good comprehensive pediatric care," he says.

Likewise, scores reported on individual physicians lose meaning because the sample of patients involved do not reflect the overall practice. "It's a punch biopsy of patients," Shoemaker asserts.

Because the definition of quality in healthcare is different for health plans, employers, consumers, and physicians, "you almost have to write an essay about each practice to determine that it is bringing good medicine to people. We mistake the numbers for their importance. They are tools, but they are not an end in themselves," he argues.

Outcomes-based measures like prescription of beta blockers after heart attack did not exist in the earliest versions of HEDIS. These measures have been added over the years as the industry has gained more confidence in the system and the science of healthcare quality improvement has become more sophisticated.

Measures approved recently have been focused on outcomes: cholesterol management after acute cardiovascular disease and follow-up after hospitalization for mental illness are two examples. That trend will accelerate in the future, according to NCQA's Schilling.

Health plans will greet more sophisticated measures with open arms, but even in its present state of development, HEDIS is providing good information, according to Robert Scully, MD, chief medical officer of Health Alliance Medical Plans in Urbana, IL. "It's one measure of how well our providers are doing in providing value. We'd like to have some outcome measure that says a 65-year old man at ABC Health Plan has a longer life expectancy than at XYZ Health Plan, but we don't have the ability to measure that," he says. "What we can say is the percentage of people who've had one heart attack that we prevented from having another, and that is a valid measure of quality."

The Data Collection Grind

Although they may quibble here and there, most people support the concept of HEDIS. However, one aspect of it brings grumbling from all quarters: the data collection process.

The painstaking activities involved in developing the HEDIS data set takes the better part of six months each year, and is time consuming and expensive for health plans. It also does not curry favor with physicians, who must open their practices for chart reviews by multiple health plans, sometimes back-to-back, sometimes simultaneously. The hassle factor varies depending on the degree to which each health plan and its contracted providers have invested in information systems, according to Schilling.

It all starts in late January or early February, when health plans begin analyzing administrative records from claims data and the like. The process, which includes generating a random sample of data on at least 411 members for each measure, must be done in accordance with precise NCQA standards. Elements not available electronically must be captured from medical record audits. Once compiled, the entire data set must be audited before being transmitted to NCQA in June. The procedures must be repeated separately for each managed care product, multiplying the work load within each health plan.

The process—though still unwieldy—has improved over the years. Ten years ago, health plans faced a steep learning curve in compiling data and had limited support from vendors, which have since developed software products that extract and analyze data from administrative systems and help streamline the process of collecting information from medical records. As well, the HEDIS data set has matured and now goes through fewer year-to-year revisions, which in turn require fewer software updates and other methodology changes.

Still, the industry is somewhat captive to the integrity of its claims data. “It’s definitely improved, but health plans still struggle with data quality contaminants,” according to MEDSTAT’s McCabe. As well, smaller plans in particular may not have invested in systems or software that will make the process easier, she says.

Many health plans have automated the process as much as possible, but can’t avoid the medical record audits. The state in which the health plan operates may be one factor. For example, in heavily capitated California, providers submit limited claims data, which in turn limits the amount of electronic data available, according to PBGH’s Hopkins.

As well, certain aspects of the HEDIS measures do not lend themselves to automation. “Of the 11 effectiveness of care measures, there’s only one that we don’t pull the medical records for. The claims data just doesn’t capture what we need,” says Jane Elliott, RHIA, MS, CPHQ, director of quality management at Health Alliance Medical Plans.

Widespread adoption of electronic medical records might reduce, but not eliminate, the need for chart audits as gains in efficiency might be cut short by legal and regulatory hurdles. “I fear access to electronic medical records will get difficult with HIPAA around the corner,” says Elliott.

Even without full-scale automation, health plans have found ways to make the process less painful. For example, Group Health Cooperative waits as long as possible before starting medical record reviews. “We found that the later we wait, the more information is available on our administrative system, and it reduces what’s needed from the audits,” explains Rashed.

Last year, Health Alliance reviewers used laptops in the field for the first time, eliminating the inefficiency of first recording data manually and then entering it electronically.

Coordinated efforts among healthcare purchasers, health plans, and providers also hold the promise of smoother data collection. The PBGH-sponsored California Cooperative Healthcare Reporting Initiative has been at the forefront of such efforts, but few others have yet to follow suit.

But that is changing. In April 2001, NCQA, the Joint Commission on the Accreditation of Healthcare Organizations, and the American Medical Association released jointly developed performance measures for diabetes care and committed to further collaborations in the future. NCQA and PBGH are also participating in a study to further streamline reporting requirements for both managed care organizations and providers. “Collaboration is the model for measurement development in the future,” says Schilling.

As the healthcare system continues to search for efficiencies, the ends justify the means, at least from the standpoint of NCQA. “The data collection is not straightforward. It requires a lot of energy and effort, but we don’t apologize too much for it. It results in information that managers and practitioners can use to get better,” says Schilling.

Health plans share that sentiment—with some limits. “The cost is significant, but we accept that it’s appropriate,” says Scully. “There’s not an alternative to get equally valid information, and if I don’t have clean data when I send it to the physicians, it’s not credible and they won’t do anything with it. However, if it were 10 times the cost, it wouldn’t necessarily be acceptable or appropriate.”

If it does not provide a one-on-one return on investment today, HEDIS is still the Cadillac of performance improvement information. “It’s the best thing we’ve got so far. The state of the art of quality management is in evolution, and it’s as rigorous as we have right now. Without it, we’d have chaos,” says David Nash, MD, MBA, associate dean and director of the Office of Health Policy and Clinical Outcomes at Jefferson Medical College in Philadelphia.

Looking Forward

As the sophistication of data improves, HEDIS will have even wider influence. But it will have its greatest impact when it is more meaningful to both providers and consumers.

HEDIS will have more influence on the average physician in practice when it is a significant factor in their incentive compensation, according to Nash. But that may be just the tip of the iceberg. “The most compelling thing will not be profiling or incentivizing physicians, but ultimately employer initiatives directed at employees. Because consumers are more and more on the front line of decision making, and ultimately a lot of these measures come down to patient compliance,” says MEDSTAT’s McCabe.

Right now, HEDIS has little meaning to the average consumer. Employers may provide overall NCQA accreditation information about each contracted health plan—information that also is usually available on the Web sites of both the health plans and NCQA—but there is little mention of HEDIS.

Recognizing the increasingly important role of consumers in making healthcare decisions and managing their own health, however, in October 2001 NCQA launched a new consumer Web site, www.healthchoices.org. In addition to NCQA accreditation information about specific health plans, the site features the “case for quality” section, which includes nationwide HEDIS scores on numerous care and service measures. Greater public awareness of the measures ultimately will raise standards of care even higher.

But already, HEDIS has left its mark. “Ten years ago, physicians didn’t push diabetics to get retinal exams or have their hemoglobin A1c levels checked two to three times a year,” says Aetna’s Warburton. “And we didn’t have staff calling patients discharged home after having heart attacks to see if they were taking their medications. That whole reminder system is there because of HEDIS.”

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