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Analyzing Health Care Measures/Health Employer (Effectiveness) Data Information Set (HEDIS)

Track: Health
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Summary: Issues discussed include determining health care measures as reported by managed care organizations.

Mr. Edward M. Mailander: I'm with Great West Life in Denver, Colorado. Our recorder is Jim Meidlinger. He is also with Great-West Life.

The subject is measuring health plan quality, and the topic is health plan report cards. Health plan report cards are published summaries of performance indicators. I'll start out with a section on the basics or fundamentals of health plan report cards and quality. Then I'll give a brief overview of the current health plan report card activity, including a brief discussion of HEDIS. No meeting of health actuaries or health care professionals for the last two years or for probably the next five would be considered an official meeting without some discussion of HEDIS, and so this will be an official meeting on health care subjects because we have touched on the subject of HEDIS. Also, I want to give you some information about the Society of Actuaries (SOA) Medical Effectiveness Task Force which looked at health plan report cards and health plan measures. Then I'll have a few concluding comments.

Since one of the stated fundamental purposes of health plan report cards is to measure health plan quality, I want to start out with a couple of definitions of quality as a point of reference. The first definition was developed by United Health Care, and it has three parts. It says that quality health services are those that are appropriate, performed well, and achieve results. The second definition touches on many of the same issues and comes from the Institute of Medicine. It defines

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quality as the degree to which health services increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Both of these definitions refer to outcomes and also appropriateness.

Just to put health plan report cards into an historical context, here are some of the major milestones. The first widely used, widely distributed health plan report card was not for a particular health plan but for a health program. In 1988, the Health Care Financing Administration (HCF) started publishing hospital mortality data, which was a published summary of performance. In 1992, there was some health care reform. Report cards were an important part of the federal health care reform program. There was specific mention of health plan report cards. Many state initiatives also included health plan report cards.

The next major milestone I selected is November 1993, when HEDIS 2.0 was released. HEDIS is a standardized definition for producing a health plan report card, primarily focused at health maintenance organizations (HMOs). There was the HEDIS 1.0, but it wasn't widely used. HEDIS 2.0 was perhaps the first viable, widely used health plan report card.

I'm going to talk about some of the technical issues associated with health plan report cards. I came up with four categories of measures which I've observed. For the first category, technical, which is the broadest one, I had four subcategories: structural, process, outcomes, and appropriateness. I view structural measures as how a health plan is organized and staffed. It is the potential to do good. An example of that would be percentages of physicians which are board certified.

The second type of technical measure is process, which are how things are done. An example of that would be mammography rates. Mammograms, in and of themselves, do not produce better health. In fact, the argument may be made that because the woman is exposed to more X-rays, it could be detrimental to a person's health. I view mammograms as a process. Its purpose is the early detection of cancer. The earlier it is detected, then the better the survival rates. Immunization rates are a process measure also.

The third item is outcomes. Outcomes might be considered the scientific gold standard for health plan report cards. You want to improve the outcomes as a result of the delivery of health care, so you want a healthier population, and a population which lives longer. One of the problems with measuring outcomes is, with respect to health, many results take a long time to develop. If you immunize children before age two, you have to wait until they're age 14 or 15 to see how well you did. You can't immunize them this week and see the results next week. You have a long timeframe associated with outcome studies. Also, the bad outcomes are so small

that you would have concerns about having enough data to be credible. In any given health plan there are very few people having adverse results.

Appropriateness was mentioned earlier in the definitions of quality health care and it is a technical measure. It isn't an outcome measure; rather it indicates how the service was performed. Was the service performed in a way which is consistent with current medical practice?

The other three categories of measures which I identified were access, satisfaction, and financial. I've seen access measures identified in a broad variety of ways. Access can be measured as an opportunity to get health care, which means how many physicians have an open practice. Another example is how many physicians of a certain type are within a certain mile radius of the member. HEDIS uses an access measure of how many members receive care. So there are many different ways of measuring access.

Satisfaction means the member satisfaction—their satisfaction with the health plan, the health plan benefits, their physician, and treatment by the office staff. It's their view of the quality of care they received. There are many different ways of measuring that satisfaction. One of the problems with satisfaction is that you are not really sure what you're measuring when you ask someone, Are you happy with your health plan? That is because it is a measure which combines several things. The other day someone was telling me about a recent study of some HMOs in Massachusetts, and that you could divide those HMOs into two groups: those health plans which scored high on member satisfaction, scored low on technical quality measures, and the other HMOs scored high on technical quality but low on member satisfaction. Member satisfaction doesn't necessarily tie directly into quality, but it's certainly an element of health plan report cards. No contemporary health plan report card is complete without a measure of member satisfaction.

The final category is financial measures. Cost is not an element of quality. It is an element of value, which is quality divided by cost. HEDIS and some other health plan report cards include financial measures.

I believe health plan report cards are good. I believe that they will lead to quality improvement because you can't improve what you can't measure. However, not all is wonderful in the world of health plan report cards, and here's what I believe are some philosophical issues.

The first one is conflict between report cards and quality improvement. I think the classic model of quality improvement is generally in a confidential environment; the feedback is given to the people performing the action. They are given feedback so

that they can improve what they are doing. Health plan report cards are for public dissemination, to help consumers in their buying choices. There is a philosophical conflict between health plan report cards and quality improvement.

A second issue is the danger of focusing on the limited number of measures. Even HEDIS 2.0, which has approximately 60 measures in it, only measures 60 things. The delivery of health care may be the most complex of human activities outside of, of course, a pension plan valuation. There is a danger in looking at a limited number of measures. If you're looking at something, you've made choices in not looking at something else, and that could be a problem. For example, I know of no health plan or anybody that would have mammography rates on the report card but not PAP smear rates. The health plan would say, "We've got to keep our costs constant, so let's increase our mammography rates and do less PAP smears, and we'll look good on the report card."

The third issue is that there is disagreement on what should be measured. If you take HEDIS's 60 measures, you could find a large number of experts who say, well, some of those are OK, but half of them are the wrong thing. There is no universal agreement of what should be measured.

Finally, there are incentives for health plans to avoid high-risk patients, especially if the health plans are measuring outcomes. Adverse outcomes are generally associated with the higher risk patients, and health plans could avoid these high-risk individuals to improve their health plan report card results.

Continuing on the basics, I'll go into what I call technical issues. I've identified ten technical issues, and many of these overlap. The first one is data quality. Health plan report cards are summaries of data, and so I won't belabor the point of data quality, but that is certainly the starting point. Summarizing bad data doesn't do much good. Another technical issue is the source of the data. Administrative data and medical records are generally the two sources of data. Administrative data are claims data; HEDIS allows several of the statistical measures to be calculated either using administrative data or extracts from medical records. It does matter which you choose in the results because administrative data, while it has much greater volume and is cheaper per record, doesn't have the accuracy or the clinical richness of the medical records or medical record extracts.

I talked to some people who had worked on the HEDIS report card pilot project where there were 21 health plans that had submitted data, and they tried this on one thing in particular: immunization rates. The HMOs generally used medical record extracts, and at least one organization was a preferred provider organization (PPO), and it used claims data. What the PPO found was that its immunization

rates for children under two were much lower than the HMOs. This PPO did some follow-up because they were concerned about these very low rates and found that many claims didn't come in with the immunization coded on it. It was part of an office visit. If you used the medical records, they showed the immunization(s) that the medical staff are good about recording. So they're good at keeping track of that sort of data in the medical records, but if they aren't going to be paid more for it, or even if they are, it doesn't necessarily get transferred into the claims records.

There have been a couple of studies that I know of which compared administrative data with medical records. I believe both of them were sponsored by HCF because they were interested in this issue, and they looked at the match between the medical records for key data elements and the claims data. They found the match was somewhere between 50% and 80% on these key data points, not between 80% and 100%, and it varied depending on the nature and severity of the medical incident. Heart attacks probably showed up in the claims data. Immunization may not have shown up. Lower cost services may not show up and certainly services that weren't specifically reimbursed didn't show up in the administrative data. There is an important issue here about whether you use administrative data or medical record extracts. Medical record extracts are expensive.

Another more technical issue is risk adjustment. If you're measuring outcomes for some process measures, there is a need to adjust for differences in covered populations. For this group I don't think I need to expand on that, other than to comment on the paper prepared by the risk adjustment work group recently produced by the SOA. It is an excellent piece of work, and it is very comprehensive on risk adjustments and current commercially available risk adjustments. If you're interested in risk adjustments and haven't read it, I'd encourage you to get the monograph "A Comparative Analysis of Methods of Health Risk Assessment (M-HB96-1)"

Validity of measure is also another issue. You could be measuring something and think that you're measuring the right thing, but since many of the measures are process measures (many of the measures that are easy to get to and that are less expensive are process measures), you have to make sure that what you're measuring produces good results, and doesn't just seem to produce good results. Going back to the mammography example, I don't know if this is still true with the lower intensity X-rays, but I remember four or five years ago reading a book by a physician who was saying that having a mammography every year increased the probability of breast cancer because of the exposure to X-rays.

Comparability is a broad, all-encompassing issue. If you believe the purpose of health plan report cards is to allow consumers, buyers, and members to make choices between plans, you want health plan report cards which are comparable

and not different. The comparability is in the background of all of these issues. I believe it's in the background because the best we can do right now is compare two health plan report cards and hope they were prepared consistently. Then you can look and say which health plan appears to be doing better than the other on specific measures.

Standards and norms are related to the issue of comparability. There are some standards and norms that HEDIS used. They used the Healthy People 2000 Study which the government had prepared. Besides those academic perspectives, there is also value, I believe, in having national standards or norms. If you are looking at two health plan report cards, it would be nice to know what the national average is, or, probably more importantly, what is the regional average.

Regarding methodology standards, I believe it is important to have comparability, not only comparable data collection and comparable data manipulation but comparable calculations. HEDIS is a methodology standard. If you're looking at a health plan report card, and you can say it was prepared in accordance with HEDIS (I believe the current version is Version 2.5), and you had a desire to know how something was calculated, you could obtain much more detail.

Verification refers to an external audit. I believe that as health plan report cards become more prevalent, which I believe they will, there will be a demand for external audits. I think that kind of a demand will come both from the consumers and from the other health plans. We want to be sure to keep everybody honest. Credibility issues are certainly a technical issue, especially with respect to outcomes because the number of adverse occurrences can be very small. Then there's communication and interpretation. How should these results be communicated? Should they all be on a standard format? How should they be interpreted? Should interpretation be left to the experts, or should this information be generally available to everybody? I don't have an answer to any of those questions, but this is certainly an issue.

Listed here are some concepts related to health plan report cards, but they are not health plan report cards. Provider profiling is probably the closest to a health plan report card. I tend to think of it as a health plan report card for a single provider or group of providers with a different set of measures. Accreditation and credentialling tend to focus on structural issues. There is more of a relationship between accreditation and a health plan report card (in particular, HEDIS health plan report card), because the organization which started or developed HEDIS, the National Committee for Quality Assurance (NCQA), has as one of its main functions to accredit HMOs.

Medical necessity, appropriateness, and treatment protocols don't play a huge part in health plan report cards now, but may in the future. There is a certain group of health care professionals out there who advocate a stronger development of treatment protocols. Your health plan report card could then become, how well did you comply with the treatment protocol? Did you follow the treatment protocol or didn't you?

In this next section I will talk about current health plan report card activity, and I'm going to start with HEDIS. I believe it's the current gold standard for health plan report cards. Many different health care organizations have developed their own health plan report card or different flavors of it, but HEDIS has received backing from several major HMOs and several large employers, and it is emerging as the gold standard. It uses approximately 60 measures. Their 60 measures are organized into six categories. If you're interested in knowing more, you can call NCQA, in Washington, D.C., and they will send you the two-inch binder which lets you do your own HEDIS reporting. It has all the specifications of how to calculate these measures. I wouldn't rush out right now and send for it because I think they're about ready to come out with their new version. If you really want it now, you can probably get a good price on an old version.

Though HEDIS is widely used and I believe, widely respected, it is not without its critics. One criticism of HEDIS is that it tends to focus more on process, and not enough on outcomes measures. Those critics say if you are going to improve health care, you must measure the results. Another criticism of HEDIS is there's no risk adjustment methodology, and I believe it's supposed to be part of Version 3.0. I don't know its exact release date, but it's supposed to have more outcomes measures and risk adjustment.

Another HEDIS activity is that HEDIS is developing features of HEDIS or adding measures particular to Medicare and Medicaid, and as I mentioned before, there is this relationship between NCQA accreditation and HEDIS reporting. Right now, the NCQA is the biggest for accreditation, and over half of the approximately 600 HMOs in the country have NCQA accreditation, and the other half are either in the process of getting it or waiting 18 months until they can apply for it. Among the things they look at is how you are doing your HEDIS reporting, and what the results are.

Another type of report card activity comes from the Foundation for Accountability, (FAcct). It was started by the Jackson Hole Group in 1995. Dr. Elwood and his group meet in Jackson Hole, Wyoming. Its purpose isn't to develop report cards but to evaluate, endorse, and promote outcomes measures. This would be one of the groups that was critical of HEDIS. They said they didn't have enough outcome

measures, so they went off and started the FAcct group to identify outcomes measures that could be used in report cards. If they can't identify existing ones, they will encourage their development or develop them themselves.

There is the proverbial 800-pound gorilla (HCF) with respect to health care, and since they control so much of the health care spending in the U.S., anything they do with respect to report cards would, I think, have to be of interest. They have a health care quality improvement program, which is HCQIP. Its purpose was to rationalize all of their quality programs. They've had peer review organization programs. This was to make it consistent and to move from structure and process to outcomes. HCF is part of HCQIP, which I believe, is an umbrella program, and then within that there are other subprograms. HCF hopefully will focus more on outcomes as opposed to structure and processes. Medicare is using a subset of HEDIS measures as part of this quality initiative, and Medicaid has worked with NCQA to develop its own version of HEDIS.

There is also employer demand. My view is that it is mostly larger employers that are demanding these report cards—the over-5,000-lives employers. It hasn't worked its way down to the smaller employer in general. As far as member demand, I would characterize it, instead of member demand, as member interest. People read it in the paper, they're interested in this, but there is no universal demand for this. There were numerous state initiatives with respect to health care reform that included report cards, but there are ongoing state initiatives. Maryland, for example, is requiring HEDIS reporting for HMO accreditation.

Several employer coalitions in the San Francisco Bay area, Chicago, and other areas are developing or have developed HEDIS-like health plan report cards. Several of them have put their own spin on it, but they're very much interested in this health plan report card concept.

I'd like to give you some brief background information on the Medical Effectiveness Task Force. It was one of the many responses of the SOA to health care reform, and there were many committees set up in 1994. I joined the committee in the spring of 1995. I think it was actually started in the fall of 1994, and its purpose was to identify useful indicators. We went from medical effectiveness, the big concept, to health plan report cards, something we could do something about, and we ended up with the purpose being to identify useful indicators and provide guidance on methodology. We produced a report. Individuals who are interested can get a copy from the SOA. I think it is a helpful guide to evaluating health plan report cards for somebody who is really interested in them.

Here are some of the things that we did. We identified health plan report card issues. I already touched upon some of them. We also had some observations or some recommendations which I didn't mention earlier. One of the recommendations that you'll find in the task force report is we thought that there ought to be available, either as part of the health plan report card or as a supplement that the public could have access to, a detailed description methodology. Now that could be a reference to HEDIS 2.5, but if they're not using some publicly available methodology, that information should be available. We need details on all adjustments. If they're doing risk adjustments, it'd be beneficial to know what the unadjusted and the adjusted members were. The unadjusted immunization rate was 3%, but after it's adjusted, it's 98%. That was a heroic adjustment. We'd like to hear more about that.

Another issue that the group identified in the report was that plan benefits affect results. There have been surveys or studies which show how the level of member financial contribution affects member satisfaction. If you have to pay $50 or $100 a month for employee-only coverage, you start off unhappy to begin with, and then find out someone else is getting it for free.

Let's discuss financial incentives. Can members or providers affect results? How something is measured affects results. If you start measuring something, then it's going to change. So the measurement itself affects the results.

In summary, I'd like to say that health care delivery is very complex, maybe the most complex of human activities. Measuring health care quality is a difficult task. It's a complex business, and then trying to measure this complex business is very challenging. However, human performance is distinguishable, and just because it's difficult doesn't mean we shouldn't do it. I think that health plan report cards and the measurement of the delivery of health care quality is a good thing. Just because it's difficult doesn't mean we should throw up our hands and say, "Well, we may have some problems doing this, so let's not do it." Report cards are here to stay.

Actuaries can make a very significant contribution in this area. I observed the work going on with the Medical Effectiveness Task Force. Because we're familiar and comfortable around statistics and data, we're also familiar with what happens in real life in the delivery of employee benefits plans and developments of HMOs. I think that being able to have a foot in both camps is the significant contribution actuaries can make.

From the Floor: My question and comment actually relate to the last thing we discussed, which was how actuaries can make a contribution. It seems to me that for the evolution of measuring quality there'll be two ways to get there. There's

what I'll call the actuary's way, which is measuring, then observing results, and if 95% of the time that occurs, then there would be a corroboration with the medical profession saying that, empirically, that conclusion makes sense. For example, if cancer surgery was more successful on sunny days than cloudy days, there might not be a corroboration, but it might be a fact, and it might not increase measures of quality. Has the medical profession embraced the actuary yet as someone who can be a partner with them in terms of at least collaborating, if not corroborating?

Mr. Mailander: It hasn't happened that I'm aware of. I don't think the American Medical Association (AMA) called the SOA or the SOA has called the AMA. There was a physician on the task force, and he was very interested in the work we were doing and enjoyed the participation. What I've seen within health plans is that when physicians get to know actuaries and actuaries get to know physicians, there's an interest in the cooperation. So, it's happening. I might characterize it more as a grass roots thing as opposed to a structural thing. I'm not sure whether that's a process measure or a structural measure.

Mr. John M. Bertko: One of the things I'd be interested in is how HEDIS or any of the other report cards work with new technologies and new practices. I'm thinking in particular of the huge controversies about bone marrow transplants for breast cancer. Is the bad rap deserved or is anybody even attempting to make some measurements here?

Mr. Mailander: If you looked at HEDIS measures, the measures are all common or mainstream. There's no experimental surgery in there. There are no unusual things. It's reasonable because you can get more data. There are many more heart bypasses being performed than there are experimental surgeries using different types of bone marrow transplants.

Mr. Robert M. Duncan, Jr.: I was interested in the measurement of technical issues. If a plan is primarily enrolling people under age 40 who are more likely to be healthy, what about the people over age 40 who might want to choose the HMO or don't have any choice from their employer? What about the people who are 65 and older picking a health plan? What does HEDIS or any of these measures do in measuring the norms or setting up report cards that are specific to demographics, both with respect to age and region?

My second question is, is there a measure dealing with denial or discouragement of services by the plan, particularly for people who would have health conditions or people over age 40? Does the plan make reports available to members? I think this is an excellent thing that should be available to the public, particularly for people who are choosing a plan. You may have a choice of a primary provider going into a

plan, and if you had some performance measures about that provider, it might help you going into it, particularly if you're an older person.

Mr. Mailander: HEDIS has one set of measures, and they don't segment it, and if your plan has these certain characteristics, then we'll just compare you with other plans that only have people under age 40. I believe one of the HEDIS measures was a disclosure of their enrollment distribution. It escapes me whether that was in there or not, but that would be reasonable. Your question also feeds into the risk adjustment issue because that plan with all those people under age 40 could look just great on outcomes for mortality outcomes.

Mr. Duncan: Are there measures of denial or discouragement with services? In California I see a great deal of legislation approaching and I suspect it's coming in other states, requiring there be a disclosure if there are incentives paid to the provider, other than just paying the straight capitation. They want that information to be publicly reported to somebody choosing a plan. Does the plan pay money to doctors to deny services or hold services down?

Mr. Mailander: I believe that in HEDIS 2.5 there is a disclosure of the grievance rate. One of the issues that we touched on in our report was, what's a grievance? You get into definitional issues because the grievance rate would be interesting. I'd like to know what the grievance rate is if I'm trying to select between health plans because it is the complement of the measure of satisfaction. As a grievance, one health plan could say, a grievance is somebody who called in unhappy. For another plan, it's somebody who got the insurance commissioner to make a personal visit to the plan. In our report we said, the grievance rate would be beneficial to get, but you have to define what a grievance is so you can make the comparison. I believe your last question was about the distribution of this information being made available. Generally what I've seen is after health plans have gone through this, and after spending all their money, they're so happy they did this, they post it in the paper so that they look good against the competition. There's nothing requiring it. The report cards will only happen because people want them, and there is a demand for them; otherwise, they will die out.

Mr. Duncan: How do you know if a report card has been produced on the plan, and how do you get it?

Mr. Mailander: Maybe the person could get the information in Maryland. Otherwise, I suggest that person call member services in their health plan.

Mr. Martin E. Staehlin: I have a conflict. Being a consulting actuary, my motives are suspect. I'm a person of high moral character. Your information says we ought

to be able to do this, and actuaries can help. When I read your first definition of quality, it's desired outcome and current knowledge, but there is no current knowledge. It changes so fast. Then you're looking at a static measure period to period. What is the forum that's set up so that actuaries can talk to state regulators? What is the appropriate forum so that you can discuss all of these issues, specifically credibility, and how to get a good measure instead of arguing about measuring something and spending too much money trying to prove that it's right or wrong? What is the forum now or that you foresee developing?

Mr. Mailander: The forum that I have participated in hasn't been at any high political level. It's a real grass roots effort. I was interested in this, so I've talked with NCQA and made myself available to them to help on a couple of technical issues. I participated with respect to NCQA by trying to keep tabs on what they're doing and work with them where I can. With the SOA, I've left the other higher level political or regulatory involvement, which I think is where your question is directed, to others because I don't know what to do in that area.

Mr. William David Wesley: We've been getting some demand for employer level, group-specific report cards and HEDIS measures. I'm wondering how appropriate it is to prepare those things where credibility and interpretation become much more of an issue. What about report cards at the provider level, which introduces a whole new level of sensitivity?

Mr. Mailander: The issue about the employer level reporting is exactly right. The credibility issue is what will, in fact, happen when the large employer demands that of you; you end up being compelled to do the reporting and try to slap the credibility disclaimer on it. You can produce the report and take a look at it. If it looks good, give it to them and hope it looks that way next year. Or hope that you're in another area, and you won't have to deal with it. Our response in our organization would be we're trying to deliver uniform health care and your group of employees shouldn't be treated any differently than anyone else. The only difference might be risk adjustment. We have these imperfect risk adjustment methods, but we are trying to deliver health care in a uniform way. You get a better picture of the delivery of health care if you look at 10,000 data points than if you look at 1,000 data points. You get a better picture of what, in fact, is happening within that health plan. We are working on physician profiling within our organization because we believe that it is necessary in order to manage our networks. We are concerned about the number of data points, and I think we'll be looking more for key statistics rather than for 60 statistics on every physician. We'd be looking for certain key statistics; we won't just have one bright line and say if they're under this, they're bad, and if they're over it, they're good. It would vary with the data points. For example, say there's a physician, and we have just two data points. He's good and I

don't care what the data points are. Here is another physician and we have 200 data points. Now we can start making some judgments and adjust those for the number of data points.

Mr. John K. Heins: I'm curious about the current prevalence of performance measurement activity given that is not required. What's driving it? Where is it happening? Is this something that most providers look at as good and a way to improve, or is what's currently going on primarily driven by demand by key customers? As you pointed out, some of the very large groups are asking for it. Third, what is the relatively short-term prospect for expansion of this kind of activity? Is it going to be required by every state, most states, some government body, or by widespread demand?

Mr. Mailander: May I take the last question first? I could make a prediction, but it would have no basis in any specialized knowledge. I believe it will happen with Maryland. Some states will say, let's require HEDIS reporting, and some other states won't. My observation is that federal health care reform and federal mandates of that nature are not likely. However, the demand will continue. I think the demand is coming from two sources. One is the competition, the other is demand from large employers. How many plans are doing report cards? I'd guess maybe three-fourths of them, because of NCQA. All HMOs want NCQA accreditation and NCQA requires HEDIS reporting. On that basis, there are many report cards out there and a large number of companies are doing them.

Mr. William C. Cutlip: Is there any software that you are aware of that's available for doing some of the measures or putting the report cards together?

Mr. Mailander: I believe that there is some software available. I only know of one in particular, and that is from the company we are using to build a data warehouse, which is MedStat. As part of our claim warehouse, we will have standard HEDIS 2.5 and then HEDIS 3.0 reporting. I know they do that, but I also believe that some other companies, for example, GMIS, VHS, and HPR, do HEDIS reporting. These are a few that I am familiar with.

From the Floor: Are the report cards being applied on an employer basis in indemnity situations rather than an HMO situation?

Mr. Mailander: I know in the HEDIS report card pilot project that there was a PPO but I'd say most of the report cards that I've seen were of HMOs. They were tightly managed health care plans, although you could clearly do some HEDIS reporting in an indemnity situation. There are certain measures which would not be appropriate, like reporting the percentage of physicians board certified. Call the AMA and

ask them. You could apply most of the HEDIS measures in an indemnity situation, but the indemnity carrier wouldn't. I think PPOs will be doing it as a defensive measure.

From the Floor: You could make that application about the example that you gave about the board certified physicians, in terms of seeing who had been attending physicians?

Mr. Mailander: Yes.

From the Floor: Or to find out who people had used?

Mr. Mailander: You could do all the measures. Then you get into some interpretational issues. Everybody could have chosen only to go to a board-certified physician because there wasn't any positive enrollment. I'll write down 100% there. As long as there isn't this external audit and validation, I'm safe so far, right?

Ms. Joan E. Herman: I have a follow-up to that question. When you apply it to an HMO that's doing point-of-service plans, do you include data that the person went out-of-network, or is that just left out? If someone gets seriously ill and decides the HMO isn't where they want to go, is that missing from the data in terms of outcome measures or does it find its way back in?

Mr. Mailander: My understanding of the report card pilot project is that it looked at all of the data, in- and out-of-network. That same question would apply to open-ended HMOs. I think you should look at the whole thing because otherwise you can end up with a ridiculous situation. We've got one board-certified physician who makes sure that he does his mammographies and immunizations. Of course, you can never get an appointment with him, and everybody else goes out-of-network, but the report card looks great for this guy.

Mr. Darrell D. Knapp: On the risk adjustments that you're doing or that you see HEDIS doing in the future, are they an across-the-board risk adjustment or do they really do a different risk adjustment for each?

Mr. Mailander: I don't know what HEDIS is planning to do. If a person had an interest, he or she can call NCQA, and they could answer that, but I don't know what their intention is. I believe they were going beyond just age and sex adjustments.