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Data Brief

COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

The National Committee for Quality Assurance's *The State of Health Care Quality 2006*

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ABSTRACT: The National Committee for Quality Assurance's 2006 report on the performance of U.S. health plans found overall improvement in HEDIS clinical quality measures for those plans that collect and publicly report performance data. Improvements, moreover, were broad-based. There are several lessons for those pursuing high performance of the U.S. health system as a whole. Most importantly, the results show there is hope; performance on some HEDIS measures is now approaching 100 percent. Diffusion of measurement has been slow, but steady. The nation needs more and better measures of performance, mechanisms for setting standards of performance, and tools, such as performance-based contracts, for ensuring that improvement occurs.

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BACKGROUND

The National Committee for Quality Assurance (NCQA) recently released *The State of Health Care Quality 2006*, the 10th in an annual series of reports analyzing the performance of the nation's health plans.[1] These reports, based on clinical measures drawn from HEDIS[2] and reported this year by 616 plans that collectively cover more than 76 million Americans, provide remarkable documentation of the nation's progress in improving the quality of health care. The new results, which reflect plans' performance in 2005, are worth noting:

- For the seventh consecutive year, health plans that measure and report on their performance showed an overall improvement in clinical quality; however, not all plans report clinical performance information and patient experience data. NCQA recommends that all plans report in the future.

- Improvements in patient care were broad-based: for commercial health plans, performance improved on 35 of 42 HEDIS measures; for Medicaid plans, on 31 of 40 measures; and for Medicare plans, on 10

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Table 1. HEDIS Effectiveness of Care Measures, Selected Trends, 2003–2005

	2003	2004	2005
Commercial averages			
Adolescent immunization status—Combination 2	41.6	46.9	53.7
Controlling high blood pressure	62.2	66.8	68.8
Childhood immunization status—Combination 2	69.8	72.5	77.7
Beta-blocker treatment after a heart attack	94.3	96.2	96.6
Comprehensive diabetes care: HbA1c testing	84.6	86.5	87.5
Comprehensive diabetes care: Lipid control (<100 mg/dL)	34.7	40.2	43.8
Medical assistance with smoking cessation	68.6	69.6	71.2
Medicaid averages			
Adolescent immunization status—Combination 2	33.9	38.1	42.4
Controlling high blood pressure	58.6	61.4	61.4
Childhood immunization status—Combination 2	58.5	63.1	70.3
Beta-blocker treatment after a heart attack	83.5	84.8	86.1
Comprehensive diabetes care: HbA1c testing	74.8	75.9	76.2
Comprehensive diabetes care: Lipid control (<100 mg/dL)	27.8	30.6	32.6
Medical assistance with smoking cessation	65.8	66.9	65.6
Medicare averages			
Controlling high blood pressure	61.4	64.6	66.4
Beta-blocker treatment after a heart attack	92.9	94.0	93.8
Comprehensive diabetes care: HbA1c testing	87.9	89.1	88.9
Comprehensive diabetes care: Lipid control (<100 mg/dL)	41.9	47.5	50.0
Medical assistance with smoking cessation	63.3	64.7	75.5

Source: National Committee for Quality Assurance, *The State of Health Care Quality 2006* (Washington, D.C.: NCQA, 2006).

of 23 measures (Table 1). NCQA concludes that "measurement does lead to quality improvement."

- The 2006 NCQA report included, for the first time, data from 80 preferred provider organizations (PPOs), not just health maintenance organizations (HMOs) and point-of-service (POS) plans (Table 2). In many instances, the results reported by PPOs were not as high as those reported by HMOs. More importantly, however, it is now possible to get some clinical performance data from PPOs—something that only a few years ago was not thought feasible. With PPOs joining the ranks of plans that report, the number of Americans enrolled in "accountable health plans" has increased for the first time in three years (76.5 million people in 2005 vs. 69 million in 2004).

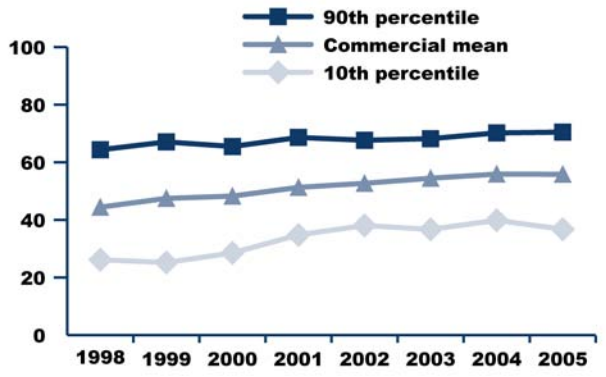
Table 2. HEDIS Effectiveness of Care Measures, Select HMO/POS and PPO Plan Averages, 2005

	HMO/POS Plans	PPO Plans
Breast cancer screening	72.0	64.6
Chlamydia screening (combined rate, ages 16–26)	34.9	28.1
Imaging studies for low back pain	75.4	72.9
Appropriate treatment for children with an upper respiratory infection	82.9	83.3
Flu shots for adults	36.3	36.8

Source: National Committee for Quality Assurance, *The State of Health Care Quality 2006* (Washington, D.C.: NCQA, 2006).

- Some quality measures are not improving. In particular, NCQA notes, "the quality of care for Americans with mental health problems remains as poor today as it was several years ago," as assessed by measures of follow-up care provided within seven days of a mental health hospitalization and measures of care for patients on antidepressant medications (Figure 1).

Figure 1. Follow Up After Hospitalization for Mental Illness—7 Days



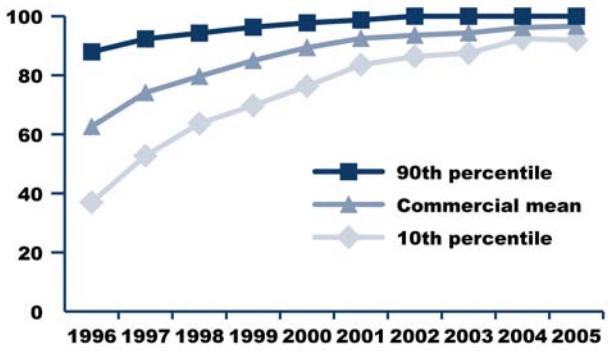
Source: National Committee for Quality Assurance, *The State of Health Care Quality 2006* (Washington, D.C.: NCQA, 2006).

RELATIONSHIP TO NATIONAL SCORECARD

The NCQA report offers some important take-away messages relating to the work of The Commonwealth Fund's Commission on a High Performance Health System, which in September 2006 released its *National Scorecard on U.S. Health System Performance*.[3] The Commission's scorecard compares national performance on 37 health system indicators against achieved benchmarks—in general, the top 10 percent of U.S. states, hospitals, heath plans, or other health care providers, or the best-performing countries. The average score across these indicators was 66 out of 100.

First, the NCQA report holds out **hope for overall improvement** in the performance of the U.S. health care system: A good example is found in the data from commercial health plans on beta-blocker treatment after a heart attack (Figure 2). In 1996, the average performance reported by health plans on this measure was 62.2 percent. The upper 10th percentile was performing at the 88 percent level. Thus, on this measure, had a score been assigned to the country and the upper 10th percentile been taken as the benchmark, that score would have been **71**. But, as one examines Figure 2, it is clear that average performance has improved greatly and is approaching perfection. The upper 10th percentile is, indeed, now performing at 100 percent, and the average across all health plans is 97 percent. So, the country's score for this one indicator now is **97**. If this type of improvement and overall performance is achievable for one indicator, why not for many more?

Figure 2. Improvements in Use of Beta Blockers After a Heart Attack



Source: National Committee for Quality Assurance, *The State of Health Care Quality 2006* (Washington, D.C.: NCQA, 2006).

The NCQA report shows that improved quality has social and economic benefits. NCQA estimates that if the entire health care system performed at the level of the top plans, between 37,600 and 81,000 lives would be saved each year. These quality gaps also lead to over $10 billion in lost productivity and nearly 65 million avoidable sick days.

Second, **diffusion of measures into wide use takes time.** HEDIS originated in the late 1980s when Daniel Wolfson, then CEO of The HMO Group, and Howard Veit, then a consultant at Mercer Consulting, created a process for developing a set of measures of health plan performance that would be responsive to the needs of employer-

purchasers.[4] Although "accountability" was not a popular term at the time, the notion underlying HEDIS was that employers—who were increasingly encouraging their employees to choose managed care plans—felt it was important to hold health plans accountable for their performance. It took about three years from the beginning of the development of the prototype set of measures, HEDIS 1.0, which was used formally by only one health plan, to the transfer of responsibility for its further development to NCQA, and to the release of HEDIS 2.0.

Further diffusion of HEDIS measurement occurred through a variety of mechanisms. Over the years, one of the most powerful has been a state requirement that traditional HMOs either become accredited through NCQA (measuring and reporting on HEDIS performance is an important part of the accreditation process) or simply report on HEDIS measures to NCQA, or to the state itself. More than 30 states now have such requirements in place. The Centers for Medicare and Medicaid Services also requires all Medicare managed care plans to report HEDIS to NCQA.

Third, **while the processes of measure development, and of measurement itself, have become much more sophisticated over the years, progress has been slow.** Some measures are still controversial, and there is room for many more measures focusing on different aspects of performance. For example, the continued poor performance of plans on mental health measures may reflect the state of mental health care in the U.S., but it also may reflect the use of measures that, at least according to those responsible for performance improvement, are poorly designed. Not having adequate measures and measurement can itself be considered a sign of suboptimal performance. Ideally, those who are concerned about the quality of performance measures would help devise better ones.

Fourth, **we need mechanisms for setting clinical standards.** NCQA, because it ties HEDIS performance to accreditation of health plans, comes about as close to a clinical performance standard-setter as we have in the U.S. Accredited commercial, Medicare, and Medicaid health plans performed better than non-accredited plans on about 90 percent of HEDIS effectiveness-of-care measures. Furthermore, on the vast majority of measures, commercial and Medicaid health plans that publicly report performed better than those that did not.

Accreditation and public reporting are important ways of holding health plans and providers of care accountable for their performance. This year, NCQA recommended that all health plans publicly release information on their clinical performance and their patients' experience. The combination of requirements for accreditation and public reporting would likely lead to improved U.S. health system performance, reduced morbidity, and reduced mortality—or, as framed by the *National Scorecard on U.S. Health System Performance,* to longer, healthier, and more productive lives.

Finally, **measurement and reporting are just the beginning of the process of performance improvement.** NCQA, in conjunction with *U.S. News and World Report,* has just released the list of top-performing health plans in the U.S. (Table 3).[5] A large number of them are in the Northeast, and three of the top five Medicaid health plans are in Rhode Island—all of the Medicaid plans in that state. For eight years, RIteCare, Rhode Island's Medicaid managed care program, has been offering bonuses to health plans meeting certain levels of performance. Are the successes of plans in Rhode Island and the rest of the Northeast applicable elsewhere? While it is possible that conditions in that region are not replicable elsewhere, this seems unlikely.

We as a nation need to discover ways to learn from the top performers and assist those plans and providers whose performance falls below the benchmark. The high-performers on HEDIS are public knowledge. The challenge now is for others to meet the benchmark—or better yet, exceed it.

Table 3. Top Health Plans

Top Ten Commercial Plans

Harvard Pilgrim Health Care
Massachusetts, Maine (HMO/POS)
Score: 93.2

Tufts Associated Health Maintenance Organization
Massachusetts, New Hampshire, Rhode Island (HMO/POS)
Score: 92.7

Harvard Pilgrim Health Care of New England
New Hampshire (HMO/POS)
Score: 92.4

Blue Cross and Blue Shield of Massachusetts
Massachusetts (HMO/POS)
Score: 91.4

Capital District Physicians' Health Plan
New York (HMO/POS)
Score: 90.8

ConnectiCare
Connecticut (HMO/POS)
Score: 90.7

UPMC Health Plan
Pennsylvania (HMO/POS)
Score: 90.7

Group Health Cooperative of South Central Wisconsin
Wisconsin (HMO)
Score: 90.6

Independent Health Association
New York (HMO)
Score: 90.6

Preferred Care
New York (HMO/POS)
Score: 90.4

Top Five Medicare Plans

Preferred Care
New York (HMO)
Score: 91.2

Harvard Pilgrim Health Care
Massachusetts (HMO)
Score: 90.3

Tufts Associated Health Maintenance Organization
Massachusetts (HMO)
Score: 90.1

Capital Health Plan
Florida (HMO)
Score: 89.9

Kaiser Foundation Health Plan of Southern California
California (HMO)
Score: 89.6

Top Five Medicaid Plans

Neighborhood Health Plan of Rhode Island
Rhode Island (HMO)
Score: 90.3

Blue Cross & Blue Shield of Rhode Island
Rhode Island (POS)
Score: 89.6

Kaiser Foundation Health Plan of Hawaii
Hawaii (HMO)
Score: 88.5

UnitedHealthcare of New England
Rhode Island (HMO)
Score: 88.5

Independent Health Association
New York (HMO)
Score: 87.3

Source: *U.S. News & World Report* and NCQA, "Best Health Plans, 2006," *U.S. News & World Report,* Nov. 6, 2006.

Notes

[1] National Committee for Quality Assurance, *The State of Health Care Quality 2006* (Washington, D.C.: NCQA, 2006). Available at http://www.ncqa.org/Communications/SOHC2006/SOHC_2006.pdf.

[2] HEDIS—the Health Plan Employer Data and Information Set—is the set of measures used by the nation's health plans to measure and report on their performance.

[3] The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from a National Scorecard on U.S. Health System Performance* (New York: The Commonwealth Fund, Sept. 2006); C. Schoen, K. Davis, S. K. H. How, and S. C. Schoenbaum, "U.S. Health System Performance: A National Scorecard," *Health Affairs* Web Exclusive (Sept. 20, 2006):w457–w475.

[4] S. C. Schoenbaum, "What's Ahead in Quality: The Managed Care Perspective," *Physician Executive* Nov.–Dec. 1993 19(6):40–42.

[5] *U.S. News & World Report* and NCQA, "Best Health Plans, 2006," *U.S. News & World Report,* Nov. 6, 2006.

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