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April 24, 2002

Marc P. Volavka, Executive Director
Pennsylvania Health Care Cost Containment Council
225 Market Street, Suite 400
Harrisburg, Pennsylvania 17101

Dear Mr. Volavka:

Keystone Health Plan East is pleased to continue working with the Pennsylvania Health Care Cost Containment Council in support of their efforts to make information on quality healthcare available to consumers, and we thank the Council for the opportunity to comment on the current report, *Measuring the Quality of Pennsylvania's HMOs.*

We are pleased to see the continued use of industry standard performance measures, specifically HEDIS clinical quality indicators and the CAHPS member satisfaction survey. We also commend PHC4 on its development of quality indicators for hospital care, and for careful attention to statistical validity of these indicators. However, we also have concerns with the current report. There are three areas of particular concern, and I will elaborate on these more below:

1. PHC4 has not highlighted the limitations in interpreting differences in performance based on the statistical accuracy of the data. Specifically, due to the sampling design of the HEDIS measures, differences between plans of less than 5 percentage points are likely due to chance and therefore not meaningful. Failure to note this limitation may cause the casual reader to misinterpret the results.
2. It is well documented that there is geographic variation within Pennsylvania in the prevalence of certain diseases, socioeconomic characteristics, and in underlying medical practice patterns. The PHC4 analyses have not adjusted for these factors, so differences in performance between health plans in different parts of the state may simply reflect such regional differences.
3. The report has focused on a cross-sectional comparison of plans across the state rather than including information on improvement or change over time, which may be more telling of health plan performance than cross regional comparisons.

With regard to the statistical limitations on interpreting differences between health plans, we note that in its reporting of hospital mortality, PHC4 has been careful to report differences that are statistically significant. This is not the case in the current HMO report, and we believe that PHC4 should use the same caution in reporting differences in HMO performance. Specifically, we suggest that PHC4 take into account the limitations in interpreting HEDIS and satisfaction measures based on sampling that are promulgated by NCQA. In the section on HEDIS indicators, each plan's performance is presented as a point measurement, and compared to the state average.

The instructions for readers found on page four of the report state:

> *"Generally, those HMOs with **higher percents** are doing a **better** job of preventing illness and helping their members stay healthy."* [emphasis in original]

There is no mention of any limitations to such comparisons. However, the statistical assumptions for sample size outlined in the NCQA specifications (see HEDIS 2000 Technical Specifications, pg. 38) are as follows:

> *"Sample size is calculated assuming . . . the detectable difference for most measures is about 10 percentage points."*

This means that if the sample is designed for a 10 percentage point detectable difference, two rates are considered equivalent unless one proportion is five percentage points more or less than the other.

Using the HEDIS statistical assumptions and the State averages provided by PHC4 to guide our interpretation, Keystone Health Plan East's performance is no different than the state average for 12 of the 16 "Staying Healthy" indicators. This is contrary to the impression given by the bar graphs, and the instructions to readers. A more valid method of displaying this data would be to show the performance of each plan with its confidence interval, stacked against each other.

The same criticism can be made about the display of CAHPS survey measures. The report first makes distinctions among scores that are not necessarily significantly different. Health plans' scores are again presented in a way that makes all point differences appear to be meaningful.

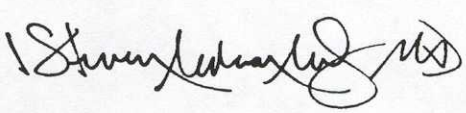
With regard to geographic variation in disease prevalence and practice patterns, we are concerned that underlying differences in disease prevalence, socioeconomic characteristics, and underlying medical practice patterns may confound health plan comparisons. For example, there is variation across Pennsylvania of 25-90% in such varied factors as specialists/1000, hospitalizations for ankle fractures, and prevalence of diabetes. While these may be difficult to adjust for, PHC4 could provide access to information on these factors that would assist interpretation of the results.

In addition, PHC4 could highlight the fact that regardless of differences among health plans, health plans as a group might be substantially outperforming the non-managed care sector. For example, on a national basis, NCQA reported in its 2001 State of Managed Care Report that in managed care plans 90.5% of people over 35 who survived a heart attack were prescribed beta-blockers on discharge from the hospital. This compared to less than 50% of people in non-managed care. The public should also be aware of how managed care compares to traditional fee-for-service care.

Finally, we believe that, in presenting only one year of data, with no reference to prior years, that PHC4 is missing an opportunity to inform the public about a key feature. Given the variation in performance among geographic areas, improvement over time within an area is an important indicator of a plan's quality improvement efforts. In the case of Keystone Health Plan East, we have made improvements of several percentage points on nearly all of the indicators presented in the report over the past three years. Some of the largest improvements have been in some of the indicators for which Keystone Health Plan East appears to have performed below state averages (notwithstanding the fact that there may be no real statistical difference).

Again, we congratulate the Council for continuing to provide Pennsylvania residents with public information on health care performance, as we all strive to improve quality across the state. We do urge caution in interpreting some of the data, as described above. We remain committed to validated measurement of performance both in Pennsylvania and across the nation, and hope our comments will assist the Council in improving future versions of this report.

Sincerely,



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