Independence
Blue Cross

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June 14, 2001

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

Dear Mr. Volavka:

Independence Blue Cross is pleased to have had the opportunity over the past year to continue working with the Pennsylvania Health Care Cost Containment Council in support of public reporting of meaningful performance data on health care in Pennsylvania. We thank the Council for the opportunity to comment on this report, *Measuring the Quality of Pennsylvania's Commercial HMOs,* and want first to applaud your efforts to improve the report based on feedback that we and others have given in the past. To continue to help provide the public with useful information on health plan performance, we also suggest some opportunities for further improvements.

The first set of comments pertains to the data on clinical and service indicators. The commentary made by the Council on the relative importance of these indicators, and caveats and comments on how to interpret the data, is as useful and necessary as the data themselves for understanding performance. For example, a plan's results in the specific areas addressed by this report cannot be used to generalize about the overall quality of services in a plan or for other clinical areas; and, for a number of reasons, comparisons among HMOs may be problematic.

We commend the Council for attempting, where possible, to use nationally recognized and heavily validated measures, such as those taken from the National Committee on Quality Assurance's (NCQA) HEDIS measurement tool. Use of such established measures improves the usefulness of comparisons since data are measured and reported in the same way. However, we suggest the Council explore ways to report more current data. The HEDIS indicators in this report are from calendar year 1999. Plans submit data to NCQA annually in June, hence we are now submitting 2000 data to NCQA. Perhaps, in the future, the timing of the report could be adjusted so that the most recent hospital and HEDIS data are available.

We do note that some measures are reported with no context or benchmarks. In several cases, these may be meaningful, but their addition without reference points or benchmarks may lead the reader to inappropriate conclusions. One example is the number of Primary Care

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Physicians (or Specialists) per 1,000 Members. A plan such as ours with a very large membership base, even with a large network, can score quite differently than a smaller plan with a similarly sized network. Network size is often driven by geographic considerations rather than purely by volume of membership.

Regarding the Hospitalization Outcome Data, we offer the following observations:

- We believe that certain measures in the report demonstrate that HMO based activities which focus on improving the health of members with chronic diseases have had a meaningful impact, since this conclusion is consistent with our own internal data. For example, KHPE has a lower than expected rate of readmission for adult patients with diabetes. We attribute this in part to the effectiveness of our diabetes disease management program. We applaud the Council for adopting our suggestion from last year to measure admission rates per 10,000 members with the disease rather than against the entire population. We also applaud the Council for risk-adjusting length of stay, complication rate, and mortality rate measures.
- The absence of specific denominators or "at risk" groups makes it difficult to interpret other data. For example, for KHPE the Admission Rate for Hypertension is reported as statistically greater than expected, based on rates calculated for the entire membership. This could mean either a higher prevalence of members with hypertension **or** a higher rate of hospitalization for patients with hypertension. Without comparing the rate of admissions for patients with hypertension, it is difficult to assess the impact of a plan's quality activities on controlling this disease.
- Lastly, as we noted last year, the Council's report continues to confirm the existence of geographical variation in procedure rates, and it remains unclear whether lower or higher rates are preferred. At a minimum, it does not appear that the variation in rates reported by the Council in this report is correlated with notable differences in outcomes. Hence we all have more work to do to understand if procedures are overused or underused in selected areas; noting that both overuse and underuse are significant quality problems in the U.S. health care system.

Again, we applaud the Council for continuing the process of providing the public with information on health plan performance in an attempt to generate a dialogue aimed at quality improvement. Independence Blue Cross remains a strong supporter of performance measurement both within the State of Pennsylvania and across the nation, and is committed to continuous improvement of our own processes and outcomes. We are pleased to continue to work with the Council on this important issue.

Sincerely,

I. Steven Udvarhelyi, M.D.
Sr. Vice President
and Chief Medical Officer