asim
american society of internal medicine



August 29, 1996

Margaret O'Kane, President
National Committee for Quality Assurance
2000 L Street, NW, Suite 500
Washington, DC 20036

Attention: HEDIS 3.0 Review of Measures

Dear Ms. O'Kane:

The American Society of Internal Medicine (ASIM) is pleased that the National Committee for Quality Assurance (NCQA) continues to refine its Health Employer Data and Information Set (HEDIS) and that interested organizations have been invited to examine the proposed measures and offer feedback.

**Four Principles**

We reiterate the four main principles that were made in our previous letter in response to NCQA's solicitation last January for proposed measures for inclusion in HEDIS 3.0: (1) participating physicians should be involved in development of health plan clinical and operational policies and procedures; (2) quality measures used to evaluate a physician should be those over which they have control; (3) a health plan's design should support prompt and appropriate access to specialty physicians; and (4) plans should report on their payment policies concerning withholds and bonuses to highlight any policies that may have an impact on quality of care.

The first two principles have not been adequately addressed in HEDIS 3.0. However, we do acknowledge that NCQA is trying to address the third and fourth principles. Although NCQA officials believe that the new HEDIS measures will force plans to pay attention to doctors' views because they focus on management of acute and chronic conditions and in-office exchanges between physicians and patients, the measures themselves rarely, if at all, call for direct physician involvement in development of case and utilization management protocols and quality assessment and improvement programs. The utilization management (UM) measure does ask for a narrative description of a plan's UM procedures and asks plans to provide information regarding "physician review of appropriateness of denials", "specialty consultation", availability to providers of decision screens and protocols, "provider and patient appeals processes" and a description of who makes medical necessity determinations. Such information would seem to require plans to have some process for involvement of physicians in development of these policies and procedures, but it is an indirect requirement at best.

As is noted in chapter 3 of the HEDIS 3.0 document, NCQA has included a set of measures it plans to test before including these measures in future HEDIS versions.

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Among the issues NCQA contends must be addressed in developing a measure to identify problems with obtaining care are: if problems in obtaining care are caused by inadequate communication about how and when referrals are to be given rather than real barriers to care; whether such a measure will work for both Medicaid and Medicare patients; and what type of questions will need to be posed with regard to Medicaid and Medicare populations to accurately reflect access to specialty care. We agree with testing the applicability of these important aspects of care.

HEDIS 3.0 does solicit information about a health plan's provider compensation arrangements, including information about withholds or bonuses and the data used to determine withhold or bonus amounts. Plans are also asked to supply their fee schedules for providers whose compensation is based on those terms. Finally, plans are asked to describe their capitation policies or procedures for Medicaid, commercial and Medicare providers and to explain any differences in capitation rates, if any, for providers for those populations. ASIM applauds these proposed additions to HEDIS.

**Hassle Factor**

While we agree that much of the data to be collected for HEDIS 3.0 is interesting to employers and purchasers, this information gathering effort must be balanced so that it will not create a hassle factor for practicing physicians. Physicians that belong to multiple managed care plans will likely have to undergo multiple chart reviews and data collection efforts in order for the managed care plans to gather data for HEDIS 3.0. These plans will probably not be able to gather all the data necessary for HEDIS 3.0 through encounter (claims) data. This means physicians will have to endure tedious surveys, site inspections, and medical records audits. The data reporting from individual physicians will likely be inadequate, particularly for preventive medicine measures, unless the physicians are using electronic medical records. Efforts should be made to collect data in ways that minimize intrusion into medical practice.

The information below describes ASIM's observations and suggestions regarding specific measures within certain HEDIS domains.

**Access/Availability of Care Domain**

**Telephone Access** -- The measure should also include "time put on hold." A true measure of telephone access is how long it takes for the patient's question to be answered, not how long it takes for someone to pick up the phone.

**Availability of Primary Care Providers** -- The listing of "number and percentage of primary care providers" with open or closed patient panels should be broken down into smaller categories of provider type, such as physician (internist, family physician) or physician-extender (physician assistant, nurse practitioner) in order to get a more accurate picture of patient access.

In addition, there is little mention made of availability of specialty services in this domain. We propose the creation of a new category "Availability of Principal Care Physicians." ASIM defines principal care as: "integrated, accessible health care services provided by medicine subspecialists and neurologists that addresses the majority of personal health care needs of patients with chronic conditions requiring the subspecialist's expertise, and for whom the subspecialist assumes care management, developing a sustained partnership with patients, and practicing in the context of family and community." ASIM supports the capability of the internal medicine subspecialist to serve as the first-contact physician

(principal care physician) for patients in his or her area of expertise. Availability of primary care providers does not accurately reflect patient access to care, particularly when dealing with the senior population. The availability of principal care by sub-specialists is a major concern.

**Availability of Mental Health/Chemical Dependency Providers** -- The framework on measuring availability of mental health and chemical dependency providers fails to take account of the complexity of care for these types of disorders. A large portion of psychiatric care is delivered by primary care physicians. Often, up to 40% of the prescriptions written by primary care physicians are for axiolytic or psychotropic drugs. In listing the number of psychiatrists, psychologists, and social workers available, it should be stressed that primary care physicians are also actively involved with the treatment of these conditions.

**Availability of Language Interpretive Services** -- This measure is only important if there is a need among the insured population. Rather than simply counting the number of physicians and staff that speak foreign languages, there should be a ratio of provider to patient for each language.

**Health Plan Stability Domain**

**Disenrollment** -- Besides calculating disenrollment rates, there should be some indication of why patients disenrolled. Patients who have died during the year should not be included in the disenrollment rate.

**Provider Turnover** -- Besides calculating provider turnover rates, there should be some indication of why providers disenrolled.

**Indicators of Financial Stability** -- This statement should list the owners of the managed care plan and indicate the percentage of the plan's governance structure that represents physicians.

**Performance Indicators** -- Beyond the measurement of medical and administrative loss ratio, there should be an indication of how profits are distributed. Do profits go to shareholders or are they reinvested into the plan? Another performance indicator should describe more specifically how the premium dollar is spent. The premium dollar should be broken down into different spending categories: administration, profit, marketing, primary care physician payment, specialty care physician payment, prescriptions, hospital, and ancillary services.

**Use of Services Domain**

The measures for inpatient utilization-general hospital/acute care, ambulatory care and inpatient utilization-nonacute care focus on site specific care without a great deal of attention paid to the care of a patient across various domains of care. The data being requested is fairly easy to provide, but may not accurately reflect the care of patients over a continuum.

**Health Plan Descriptive Information Domain**

**Board Certification/Residency Completion** -- We welcome the change whereby plans will now be asked for percentage of physicians who have completed residency training and/or are board certified. While this is a step in the direction ASIM has encouraged, we are concerned that managed care plans will nevertheless continue to insist on board certification as a minimum qualification.

**Provider Compensation** -- The reporting of physician compensation arrangements are only meaningful when they are coupled with medical outcomes data and accurate reporting of the patient mix.

**Case Management** -- HEDIS asks plans to offer information on the approach they take in managing catastrophic acute or complex chronic illness or injury and suggests the use of an illustrative example for a specific clinical condition. A mere description of a health plan's case management processes won't give an accurate picture of how those processes function. Information about the implementation of case management approaches and outcomes would improve the measure. Physician supervision of the case management process, role of physicians' decision making, the training and quality assessment of those providing case management services should also be included in the case management measure.

Thank you for full consideration of these comments.

Sincerely,

Alan R Nelson MD

Alan Nelson, MD
Executive Vice President

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