



Measuring the Quality of America's Health Care

TO: HEDIS Users

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RE: PPO HEDIS Technical Specifications

NCQA has revised the HEDIS specifications to include HEDIS reporting by PPOs, beginning in HEDIS 2007.

Background

In recent years, enrollment in PPOs has eclipsed enrollment in HMO/POS plans. While consumers and others have had the opportunity to compare performance of HMO/POS plans through the rigorous quality-reporting standards of HEDIS, PPO enrollees (who make up the majority of consumers enrolled in managed care plans) have no relevant information regarding quality of care rendered by these organizations. Public and private purchasers and regulators are interested in reviewing relevant HEDIS performance information reported by PPOs to facilitate value-based purchasing across the HMO/PPO products from which they choose.

Several large purchasers have begun to require HEDIS reporting by PPOs. Medicare Advantage (MA) PPOs will be required to report certain HEDIS measures and CAHPS performance information as of 2007. In addition, the Federal Employees Health Benefit Program (FEHBP) will require PPOs to collect performance data on five HEDIS measures in 2007 and report results in 2008. A number of PPOs have been reporting HEDIS measures to NCQA for the past several years, and many have announced their intention to report in 2006 and 2007.

Currently, standardized performance reporting by PPOs is hampered by the lack of explicit measure specifications. To address this gap, NCQA has reviewed current HEDIS HMO measures and measurement/reporting guidelines. Specifications have been adapted for use by PPOs, and recommendations were formulated and released for public comment in mid-June.

We have undertaken a number of steps to identify issues that must be addressed to ensure technical performance measure specifications resulting in meaningful, reliable and valid performance results for PPOs. These steps included the following.

- A PPO pilot in Medicare Advantage (MA) plans in 2006. This involved both data submission by MA and commercial PPOs and interviews with prospective MA PPOs on their capabilities.
- PPO data submission of hybrid measures from a few MA plans.
- Deliberations with PPO staff who are leading their organizations' efforts to assess obstacles and capabilities with respect to HEDIS-based performance measurement.
- Convening a PPO specification Technical Expert Panel, representing PPO plans that have been, or were planning to, report HEDIS data to NCQA.

Conclusions

In developing PPO HEDIS technical specifications, we strove to ensure comparability between PPO and HMO performance, wherever possible. We found that current HEDIS HMO/POS specifications—with few adaptations—can be utilized to calculate PPO performance.

NCQA has reached the following overarching conclusions that are reflected in the *Addendum to the General Guidelines*.

- *General Guidelines* language and definitions in HEDIS Volume 2 required minor changes.
- Current individual HEDIS measure specifications, including numerator and denominator criteria and exclusions, apply as written and did not require changes. NCQA will monitor whether measure specifications require revisions, based on PPO data submission.
- Reporting categories have been updated. All HEDIS measures can be reported for HMO, POS and PPO plans. Plans can report for all three product lines (commercial, Medicaid, Medicare).

Because HEDIS data submitted in 2007 will be included in *Quality Compass*, NCQA requires the data to be audited. PPOs are not required to submit HEDIS data for 2007 Accreditation.

Addendum for PPO HEDIS Reporting

SUMMARY OF CHANGES TO HEDIS 2007 VOLUME 2

- All guidelines in HEDIS 2007 Volume 2 will apply to PPOs except for the revisions noted below.
- Replace the term “MCO” with the term “organization” in all guidelines except in the section *Defining an MCO for HEDIS Reporting and Accreditation*. An equivalent PPO section, *Defining a PPO for HEDIS Reporting and Accreditation* is provided below.
- HEDIS PPO performance results will not be used in 2007 in the scoring of PPO accreditation, therefore guidelines that explicitly apply to accreditation are not relevant to PPOs.

Overview

PPO HEDIS 2007

HEDIS 2007 is the latest edition of the Health Plan Employer Data and Information Set. It is the most widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA), a not-for-profit organization committed to assessing, reporting on and improving the quality of care provided by organized delivery systems. HEDIS has become more than a set of measures; it is part of an integrated system to establish accountability in health care.

HEDIS 2007 is an important and remarkable multipurpose tool. Originally designed to address private employers' needs as purchasers of health care, it has been adapted for use by public purchasers, regulators and consumers. Quality improvement activities, health management systems and provider profiling efforts have all used HEDIS as a core measurement set. HEDIS is equally at home as part of a purchaser request, as an element of NCQA Accreditation or as the basis of a consumer report card. It is also the model for emerging systems of performance measurement in other areas of health care delivery.

HEDIS Reporting

2. Product-Specific Reporting

At the discretion of individual organizations, HEDIS results may be reported separately by product line (HMO or point of service [POS]) or combined (HMO/POS). The PPO product must be reported separately. Organizations that would like to report the PPO product line combined with the HMO/POS product line, must submit a written request for approval to NCQA. Please submit requests to the Policy Clarification Support (PCS). The term “plan” in the following guidelines can refer to an HMO, POS, or PPO.

Health maintenance organization

A **health maintenance organization (HMO)** is an organized health care system that is accountable for both the financing and delivery of a broad range of comprehensive health services to an enrolled population.

An HMO is accountable for assessing access and ensuring quality and appropriate care. Practitioners affiliated with the health care system render health care services. In this type of MCO, members must obtain all services from affiliated practitioners and must usually comply with a predefined authorization system to receive reimbursement.

	<p>A practitioner is a professional who provides health care services and is usually required to be licensed as defined by law.</p>
Point of service	<p>A point-of-service (POS) product is an HMO with an opt-out option. In this type of MCO, members may choose to receive services either within the MCO's health care system (e.g., an in-network practitioner) or outside the MCO's health care delivery system (e.g., an out-of-network practitioner).</p> <p>The level of benefits or reimbursement is generally determined by whether the member uses in-network or out-of-network services. Common uses of the term "POS" include references to products that enroll each member in both an HMO (or HMO-like) system and in an indemnity product. A POS product is also referred to as an "HMO swing-out plan," an "out-of-plan benefits rider to an HMO" or an "open-ended HMO."</p>
Preferred provider organization	<p>A preferred provider organization (PPO) is an accreditable entity whose performance NCQA assesses using the NCQA PPO Plan Accreditation standards. PPO plans take responsibility for providing health benefits-related services to covered individuals and for managing a practitioner network. They may administer health benefits programs for employers, either by assuming insurance risk or by providing only administrative services (ASO).</p>

Defining a PPO for HEDIS Reporting for Accreditation

	<p>NCQA defines a PPO plan that is accountable for service and care provided to the enrollees based on its management structure, providers and practitioners and delivery system.</p> <p>Eligible PPO plans combine a set of plan management responsibilities with a provider network that covers a distinct geographic area and performs the full range of functions NCQA evaluates for PPO plan accreditation—enrollee communication, utilization management, appeals, complaint handling, practitioner credentialing and quality improvement.</p> <p>The management functions of an organization may support several PPO plans that cover different geographic areas, but NCQA evaluates the administrative functions in conjunction with the performance of a PPO plan covering a geographically distinct area.</p>
Legal entity	<p>The first issue NCQA considers when defining a PPO is legal structure. The goal is to identify the legal entity accountable for providing service and care to specific groups of enrollees.</p>
Provider network	<p>A PPO plan has a unified practitioner and provider network, covering a distinct geographic area, from which an enrollee may choose any practitioner or provider. If there are separate and geographically distinct provider networks, NCQA may consider each network, along with the accompanying management structure, to be a separate PPO plan.</p>
Centralization	<p>NCQA considers the degree to which key functions performed by the PPO plan are centralized. If key functions are decentralized with distinct policies and procedures for different units, NCQA may determine that there is more than one PPO plan. To the extent that a PPO performs the following activities, NCQA expects the PPO plan to have a single program or policy for each:</p>

- quality improvement (QI)
- utilization management (UM)
- credentialing and recredentialing (CR)
- enrollee rights and responsibilities (RR).

Licensure

Many states do not require licensure for PPO plans. To the extent that PPO plans are licensed by the state, one PPO plan may have multiple licenses, particularly if the PPO's service area crosses state lines. If an organization has multiple licenses within a state, NCQA may conclude that there are multiple PPO plans, taking into account other structural issues discussed above.

NCQA recognizes that the management structure, licensure and network structure of each PPO is unique. NCQA works with individual PPO plans to clearly identify and define the PPO. NCQA may determine that multiple HEDIS reports are required for an accreditable entity. A PPO that needs assistance defining the PPO plan should contact the NCQA Accreditation program manager at 202-955-5147.

26. Self-Insured Members**Administrative Services Only**

For self-insured members, for whom the organization provides administrative services only (ASO), include these members in the organization's HEDIS reports within the appropriate product line if:

- These members are managed in the same way as those for whom the organization assumes financial risk, **and**
- The organization is responsible for administering both in-network and out-of-network claims for them, whether or not this is done through a third party.

Membership Changes**30. Members Who Switch Products****Measures with a continuous enrollment requirement**

If the organization reports separately by product, members who switch from the commercial HMO product to the commercial POS product (or vice versa) in the time specified for continuous enrollment for a measure are continuously enrolled and should be included in the product-specific HEDIS report in which they were enrolled as of the end of the continuous enrollment period. For HMO or POS HEDIS reporting, count enrollment in a PPO product as a gap in continuous enrollment. For PPO HEDIS reporting, count enrollment in a HMO or POS product as a gap in continuous enrollment.

An organization may use claims data from all products even when a gap in enrollment occurs.

Measures without a continuous enrollment requirement

If the organization reports commercial HEDIS HMO and POS separately, members who switch between product lines during the measurement year should be reported in the product to which they were enrolled on the date of service (outpatient services) or date of discharge (inpatient services).

45. Obtaining Information From Medical Records

An organization using the Hybrid method is responsible (as are its contractors) for determining compliance with HEDIS measurement specifications. Information from the medical record may be abstracted by:

- The organization or contractors hired to conduct chart audit, **or**
- Practitioners of care.

Organization or contractor abstraction

The organization may count a service if the medical record contains:

- A note indicating the date the service was rendered
- The result (when applicable).

Entries made in the medical record when the service was provided must include:

- The date and the result (when applicable), **or**
- A consultation, laboratory or imaging report.

All medical record entries must be made and all services must be rendered by the deadline for delivery of the service established in the measure (e.g., by the child's second birthday for the *Childhood Immunization Status* measure). Retrospective entries do not count toward HEDIS.

Abstraction of electronic medical records

The organization may review the electronic medical record screens at the practitioner's office, or review print-outs (including screen shot print-outs) of the record containing the patient's name, the practitioner's name and the date from the practitioner's office. The organization should develop and implement confidentiality guidelines consistent with electronic medical record abstraction. See General Guideline 46 for further information.

Practitioner abstraction

The organization may review a mailed copy of the record containing the patient's name, the practitioner's name and the date from the practitioner's office. Although faxing relevant portions from the medical record is acceptable, it is not a preferred method because of patient confidentiality issues. Regardless of the method used, the organization should develop and implement confidentiality guidelines. NCQA does not approve or review medical record abstraction tools or training materials.

Guidelines for practitioner abstraction

An organization for which a practitioner supplies measure-specific information from a medical record must use an abstraction tool to:

- Provide guidelines for abstraction.
- Complete quality control processes, such as interrater reliability or rater-to-standard reliability validation.

The organization must provide guidelines for practitioner abstraction. Verbal or written guidance should include clear instructions for applying the technical specifications to medical record review. Instructions are subject to review by the HEDIS Compliance Auditor. The organization does not need to use the same tool for practitioner chart abstraction that it uses for the chart abstractions its contracted vendors perform; however, all abstraction tools are required to have all necessary data elements and are subject to review by the HEDIS Compliance Auditor.

Processes used to determine the validity and integrity of abstracted data, including interrater reliability, quality control or rater-to-standard tests are subject to review by the HEDIS Compliance Auditor. The organization must include these records in

the HEDIS Compliance Audit medical record review validation.

The organization should not use practitioner attestation forms because they do not require the practitioner to verify services using the medical record.

**Medical record
pursuit strategy**

Several measures use the term “PCP”; however, a PCP does not have to be an assigned practitioner and the plan may create its own strategy for determining the best medical record to pursue in order to obtain information for hybrid measures.
