NCQA: Advancing the Quality Agenda in Managed Health Care

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Robert Swenson, a 64-year-old white male, is admitted to the internal medicine ward of a community hospital with substernal chest pain, shortness of breath, and new Q waves in leads II, III, and aV_F on electrocardiogram. Reviewing the patient's chart during the course of his admission, the senior resident, Pamela Hurst, notes several risk factors for an acute myocardial infarction (MI): a history of intermittently elevated systolic blood pressure (perhaps treated in the remote past; the chart is unclear), a history of hypercholesterolemia (with a fasting low-density lipoprotein [LDL] cholesterol level of 142 mg/dL on the patient's current dose of statin therapy), a prior MI (approximately 8 months before the current admission), and a pack-a-day smoking habit (with a 30 pack-year history). Furthermore, Dr. Hurst sees no evidence that Mr. Swenson has been taking a β-blocker since his previous MI. "Why," Dr. Hurst says to herself with some exasperation, "didn't anyone DO anything to prevent this man's second heart attack? Isn't anybody watching this patient? Doesn't anybody care?"

Mr. Swenson's community-based physician does care. However, from what is known about Mr. Swenson's history, it appears that Dr. Hurst is correct that Mr. Swenson has not received the standard of care for a patient with known risk factors for a second heart attack.

Unfortunately, despite the concern and commitment of tens of thousands of community physicians, evidence clearly suggests that Mr. Swenson's history is not unique. Although the science of risk factor management in patients with cardiovascular disease is well advanced, data clearly indicate that hypertension—especially isolated systolic hypertension—is not well controlled [1], that LDL cholesterol is not brought to target levels in most patients with cardiovascular disease [2], that physicians do not routinely medicate patients with β-blockers after an acute MI when it would be appropriate to do so [3], and that physicians frequently do not counsel their patients about smoking cessation—one of the few strategies that has clearly been shown to increase the rate at which smokers quit [4].

These and many other problems of health care quality are prevalent throughout the U.S. health care system, regardless of the type of insurance coverage a patient has [5]. But opportunities exist to address many of these problems. As designed by the National Committee for Quality Assurance (NCQA), the purpose of health plan accreditation is to evaluate and report to the public the extent to which managed care organizations (MCOs) have succeeded in capitalizing on opportunities to improve the quality of the care and services they provide. In this way, NCQA accreditation attempts to reveal a managed care plan's commitment to quality improvement.

The following article provides a basis for understanding the mission and quality oversight activities of NCQA and highlights some major successes in quality improvement achieved by health plans that consistently monitor and report on their performance through NCQA. Also discussed are ways in which physicians are affected by, if not directly involved in, the health plan accreditation process.

NCQA Overview: Origin, Mission, and Quality Oversight Activities

This year marks NCQA's 10-year anniversary as an independent, not-for-profit organization that both establishes quality standards for MCOs and reviews and reports on the status of individual health plans. Its mission is to improve the quality of health care and to provide information so that patients, payers, physicians, hospitals, and other interested parties can better judge how health plans compare on the basis of quality and, thereby, make more informed decisions when choosing among health plans. NCQA is governed by a Board of Directors consisting of employers, consumer and labor representatives, health plans, quality experts, policy makers, and representatives from organized medicine.

NCQA evaluates and reports on the quality of health plans through 2 voluntary activities: accreditation of MCOs and publication of measures of performance in the Health Plan Employer Data and Information Set (HEDIS®).

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Table 1. Examples of Standards and Performance Measures that Comprise NCQA's Health Plan Accreditation Program

Category	Examples
Access and Service	Do plan members report problems in getting needed care? Are doctors in the plan free to discuss all available treatment options? How well does the plan follow up on grievances?
Qualified Providers	Does the plan regularly check the licenses and training of physicians? How do plan members rate their personal doctor or nurse?
Staying Healthy	Does the plan issue guidelines to its doctors on how to provide appropriate preventive care services? Are plan members receiving tests and screening as appropriate?
Getting Better	How does the plan evaluate new medical treatments, devices, and procedures to ensure that members who are ill have access to safe and effective care?
Living with Illness	Does the plan have programs in place to help ill members manage chronic conditions such as asthma? Do members with diabetes receive retinal examinations as needed?

NCQA = National Committee for Quality Assurance. (Adapted with permission from National Committee for Quality Assurance. What is MCO accreditation? Available at www.ncqa.org/pages/programs/accreditation/mco/accred.htm. Accessed 21 Apr 2000.)

NCQA began accrediting MCOs in 1991 in response to the mutual need of employers and health plans for standardized, objective information about the quality of care provided by health plans. Approximately half of the nation's MCOs, covering 75% of all individuals enrolled in health maintenance organizations (HMOs) and point-of-service plans, voluntarily participate in the NCQA accreditation process, and a growing number of large corporations (eg, Ford, Chrysler, General Electric, IBM, Boeing, Xerox) require or request NCQA accreditation of the health plans with which they contract. To achieve accreditation, a health plan is surveyed and graded according to rigorous national standards designed to evaluate the quality of the plan's clinical and administrative systems.

NCQA also manages the evolution of HEDIS—a set of more than 50 performance measures used to evaluate and compare the results a health plan actually achieves in key areas of care and service. These areas include preventive care (eg, immunization and mammography rates), management of acute and chronic illness (eg, rates for specified surgical procedures, rates of retinal examination in patients with diabetes), and member satisfaction (evaluated using the Consumer Assessment of Health Plans Study [CAHPS®] instrument). HEDIS is updated regularly to reflect evidence in the clinical outcomes literature as well as advances in the science of performance measurement. The latest version, HEDIS 2000, includes several new measures, including an outcome measure related to heart disease (ie, controlling hypertension), a chlamydia screening measure, a new measure related to asthma, and a measure related to menopause counseling.

Approximately 90% of the nation's HMOs reported HEDIS results in 1998 [6]. A health plan can choose to reveal its HEDIS data to the public or can opt not to have this information publicized. Health plans that disclose their HEDIS data score higher on these performance measures than do plans that do not allow their HEDIS results to be made public [6].

The NCQA Accreditation Process

NCQA accreditation is designed to provide comprehensive and reliable judgments about quality, so that those who choose among health plans can do so with better information. NCQA accreditation attempts to answer such questions as:

- What does "quality" in health care really mean?
- What day-to-day health care activities (systems and processes) are important in assuring that a health plan provides quality care and service?
- How can these key activities be measured, in ways that are reliable, meaningful, fair, and most amenable to telling the public about what really goes on within a given health plan?

How is Quality Health Care Defined?

Researchers have found that patients, employers, physicians, and others have identified remarkably similar elements that help define high quality in health care [7]. From the patient's point of view [8], these elements might be expressed as follows:

- Will I have access to care when I need it?

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NCQA Plan Performance: **** best; *** very good; ** good; * fair; ○ poor

Here are the results of your search: *New Search*

Plan	Product Line/ Product	Access & Service	Qualified Providers	Staying Healthy	Getting Better	Living with Illness	Overall Accreditation
Plan Alpha	Commercial HMO	****	***	****	***	***	EXCELLENT
Plan Beta	Commercial/POS	**	*	*	****	*	ACCREDITED
Plan Delta	Commercial/POS	**	○	**	*	*	PROVISIONAL
Plan Gamma	Commercial/ HMO	***	**	***	**	****	COMMENDABLE

Figure 1. The National Committee for Quality Assurance (NCQA) reports the results of its accreditation survey of a health plan in 5 categories that reflect key elements of quality care. These results are presented in the form of a health plan "report card" that allows comparison with other health plans. (Reproduced with permission from the National Committee for Quality Assurance. NCQA's health plan report card. Available at www.ncqa.org/pages/hprc/index.html. Accessed 2 May 2000.)

- Will I be able to choose my doctor, hospital, and other sources of health care?
- Will the providers available to me be appropriately qualified, licensed, and/or certified according to standards of the health care professions?
- Will the health plan's providers help me stay healthy as well as help me to get better if I am sick? Will I be appropriately cared for if I develop a chronic illness?
- Will I be treated with respect and courtesy? Can I expect that waiting time on the telephone and other administrative inconveniences will be minimized? Will all confidential information be respected as such?

During the NCQA accreditation survey, a health plan is evaluated against 60 standards that fall into 1 of 5 categories that reflect the elements of quality care defined above (Table 1). The final results of this evaluation are presented in an easy-to-read visual format allowing comparison of different health plans (Figure 1). These health plan report cards can be accessed on the NCQA Web site (www.ncqa.org/pages/hprc/index.html).

What Activities are Important in Assuring Quality?

NCQA focuses on systems and processes that are critical to the delivery of high-quality care and services. Health plans are examined in 6 core areas.

Quality improvement. A high-quality health plan must regularly and conscientiously assess the quality of care and services provided by its physicians, hospitals, and other health professionals and administrative staff, and take action to identify ways to continually improve. NCQA assesses how well each health plan accomplishes this.

Utilization management. Most health plans "manage" the use of resources (eg, hospital days, clinical procedures) by reviewing the appropriateness of the resources used and approving those that are medically necessary. NCQA assesses this process to ensure that the criteria used in these decisions are medically sound, based on good science, and developed with the input of the plan's practicing physicians. NCQA accreditation standards require that these decisions take into account the individual circumstances of patients.

Preventive health. NCQA standards require health plans to have well-developed programs stressing both treatment of disease and prevention of illness. Ensuring high-quality preventive care requires well-coordinated processes and support systems for identifying and reaching out to members who require preventive services. Preventive health care includes many interventions familiar to primary care physicians, such as immunization, appropriate cancer screening, and risk factor assessment in patients based on age, sex, or existing disease.

Members' rights and responsibilities. A high-quality health plan will ensure that members' rights are recognized and protected. For example, every patient has the right to clear information about the plan's benefits and services, the right to privacy, and the right to file complaints and grievances (and to timely and fair resolution of these problems when they arise). NCQA accreditation standards give doctors and patients the right to appeal adverse decisions about medically necessary care to an independent, external review organization.

Credentialing. The basic mechanism for ensuring the quality of health care providers—both individual and institutional—is evaluation of qualifications and, to the extent possible, actual performance. NCQA accreditation standards require that health plans verify their member physicians' education, training, and licensure and that plans check appropriate databases for information about sanctions and malpractice.

Medical record-keeping. An essential element of providing care is ensuring the integrity of the medical record as well as the confidentiality of sensitive information contained within it. NCQA accreditation standards include 6 critical elements of the medical record:

- Significant illnesses and medical conditions are indicated on the problem list.
- Medication allergies and adverse reactions are prominently noted in the record.
- Past medical history (for patients seen 3 or more times) is easily identified and includes serious accidents, operations, and illnesses. For children and adolescents (age 18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.
- Working diagnoses are consistent with findings.
- Treatment plans are consistent with diagnoses.
- There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.

How Does NCQA Measure These Activities?

The "structure, process, outcomes" framework for assessing health care quality, described by Avedis Donabedian more than 20 years ago [9], continues to guide NCQA's efforts to evaluate quality of care. Historically, accreditors have relied on on-site evaluation against standards as a means by which to evaluate the elements of health plan structure and process (ie, systems capability and control). More recently, standardized performance measures (eg, HEDIS) have permitted valid measurement of some health plan results (ie, process and outcomes). In the NCQA's current Accreditation 2000 program, accreditation decisions are based on both compliance with quality standards and health plan results. NCQA is not the only organization that accredits health plans. Both the Joint Commis-sion on Accreditation of Healthcare Organizations (JCAHO) and the Utilization Review Accreditation Commission (URAC) have accredited a small number of health plans; these accreditation programs are standards based.

Evaluation of standards compliance. A survey team, including at least 1 physician as well as managed care experts, reviews health plan documents and interviews health plan staff. The survey team evaluates the plan findings against a set of standards in each of the 6 systems and process domains described above and scores the plan's compliance with each standard (from full compliance to noncompliance). A total score is then generated algorithmically. This score, the *standards compliance score*, accounts for up to 75 of the 100 possible points needed for accreditation. A significant proportion of the standards compliance score is based on a random review of health plan files. The surveyors randomly select and review files from 4 areas: credentialing, utilization management denials, emergency department denials, and complaints and appeals. The health plan is not notified ahead of time which files will be pulled.

Evaluation of health plan results. The health plan also submits results on selected HEDIS clinical measures (Table 2) as well as results from NCQA's standardized consumer survey (ie, CAHPS®). HEDIS results are reported separately for commercially insured persons, Medicaid beneficiaries, and Medicare beneficiaries. HEDIS and CAPHS® results are scored against regional (HEDIS only) and national percentiles for each measure, and scores across measures are tallied (Table 3). A health plan can earn up to 25 points—half from clinical performance, half from performance measured through patient survey—to be added to the 75 possible points from standards compliance.

Final accreditation decision. The total findings of the survey team undergo both internal and external review to ensure consistency and reliability among evaluators. External review is conducted by the Review Oversight Committee (ROC), a panel of physicians with significant managed care experience. The ROC assigns 1 of 5 possible accreditation levels (excellent, commendable, accredited, provisional, or denied) based on the plan's level of compliance with NCQA standards. Health plans receive separate accreditation outcomes by product line—commercial, Medicaid, or Medicare.

NCQA performs on-site reviews at least every 3 years but receives annual HEDIS and CAPHS® data from

Table 2. HEDIS Effectiveness of Care Measures Required for NCQA Accreditation

	Required for		
Measure	**Commercial Populations**	**Medicare Populations**	**Medicaid Populations**
Childhood immunization status	√		√
Adolescent immunization status	√		√
Advising smokers to quit	√	√	√
Influenza shots for older adults		√	
Breast cancer screening	√	√	√
Cervical cancer screening	√		√
Prenatal care in the first trimester	√		√
Check-ups after delivery	√		√
β-Blocker treatment after a heart attack	√	√	√
Comprehensive diabetes care (retinal examination rate only)	√	√	√
Follow-up after hospitalization for mental illness	√	√	√

HEDIS = Health Plan Employer Data and Information Set; NCQA = National Committee for Quality Assurance.

Table 3. Tallying HEDIS/CAHPS® Results

For each Effectiveness of Care result or HEDIS/CAHPS® result, if the health plan's rate:	**The score is:**
Meets or exceeds the 90th percentile threshold nationally	1.25 points
Meets or exceeds the 75th percentile threshold regionally or nationally	1.10 points
Meets or exceeds the 50th percentile threshold regionally or nationally	0.85 points
Meets or exceeds the 25th percentile threshold regionally or nationally	0.50 points
Falls below the 25th percentile threshold regionally or nationally	0.25 points
Is not reported or receives a "not report" (NR) on audit (up to 2 Effectiveness of Care measures for each product line/product)	0 points

CAPHS® = Consumer Assessment of Health Plans Survey; HEDIS = Health Plan Employer Data and Information Set.

each health plan to enable accreditation to be updated on a yearly basis.

Ensuring Quality in the Accreditation Process

NCQA recognizes the importance of maintaining the integrity of its accreditation process. Several policies and procedures, including some previously mentioned (eg, random review of health plan files, internal and external review of survey team findings), are in place to ensure that health plan evaluations are accurate and objective and that there is no conflict of interest or potential to "game the system." For example, all NCQA surveyors are required to disclose any MCO affiliations, including consulting agreements, before they may participate in any way; if MCO relationships are disclosed, the surveyors are prohibited from participating. Also, NCQA controls when a health plan can pull out of the accreditation process; once a health plan has committed to being evaluated, it cannot avoid public reporting of the accreditation survey results (eg, if accreditation is denied). In addition, all HEDIS performance data submitted by health plans undergo a formal compliance audit by external, independent auditors who must be certified by NCQA. Auditors are listed on the NCQA Web site and include large management consultants, among others.

Can Accountability Efforts Improve Quality?

According to NCQA data collected from hundreds of MCOs between 1996 and 1998, the answer appears to be a definite "yes" [6]. NCQA reports that health plans that consistently monitor and publicly report on key performance measures related to preventive care and management of chronic illness showed significant improvements in quality over this 3 year period. Furthermore,

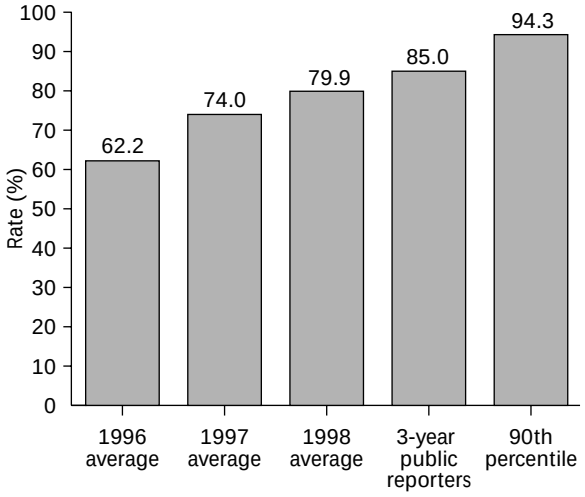

Figure 2. Health plan reported percentages of members aged 35 years and older who were hospitalized and discharged alive with the diagnosis of acute myocardial infarction and who received a prescription for β-blockers. The figure provides a summary of the industry-wide performance of health plans that reported on this measure in 1996, 1997, and 1998. (Adapted with permission from National Committee for Quality Assurance. The state of managed care quality—1999. Available at www.ncqa.org/pages/communications/news/somcqrel.html. Accessed 21 Apr 2000.)

the longer that plans have been reporting data to NCQA, the better their performance [6].

For example, in 1996, health plans began measuring and reporting the percentage of members aged 35 years and older who were hospitalized and discharged alive with the diagnosis of acute MI and who received a prescription for β-blockers. In the first year of public reporting, health plan rates for appropriate β-blocker use averaged 62.2% of the eligible population. By 1998, the average had increased to 79.9%, with plans that reported data in all 3 years having even higher rates (Figure 2) [6]. NCQA calculates that if industry-wide performance were at the level of plans that performed in the 90th percentile, at least 4280 additional cardiac deaths would be avoided annually. Thus, holding health plans accountable for quality of care truly can have a positive impact on the lives of individual patients.

Reflecting back to the patient in the opening scenario, Mr. Swenson theoretically could had been a member of one of the health plans that reported the highest rates of β-blocker use, in which case at least 1 of the risk factors for his second MI most likely would have been addressed. Or, he could have been a member of a plan such as Healthsource Massachusetts, which offers training to its primary care physicians on how to counsel adult patients about smoking cessation and which monitors its member physicians' success at addressing smoking with patients [10]. But, as NCQA data show, MCOs are very different—both with respect to their commitment to improving the quality of care delivered to their members and with respect to their success at executing that commitment. This variation is largely unapparent to physicians and is especially invisible to patients. Accreditation attempts to reveal an MCO's demonstrated commitment to quality by evaluating its performance results and reporting that information to the public.

How Does Health Plan Accreditation Affect Physicians?

Although a physician might believe that accreditation is something that happens only to the health plan, the truth is that a practicing physician may be affected by, or even participate in, this process in several ways.

Joining a Plan Network

Involvement begins when a physician applies to join a health plan's panel of participating providers. NCQA accreditation can help assure a physician that the health plan has been judged to be of sound quality based on external and uniform standards. The physician can trust that if the plan is NCQA accredited, it has well-defined, fair processes for making coverage decisions and an established protocol for determining whether physicians are qualified to provide health care to its members.

To be eligible to join the network of an accredited plan, a physician is evaluated based on quality standards for unrestricted license, malpractice history, sanctions, appropriate training, and office availability and coverage. The physician is then reviewed by a committee of other network participating physicians, and his or her application for participation is accepted or rejected. (This process parallels the process of applying for admitting privileges to a hospital.) Every 2 years the plan also must demonstrate that it has a process in place to re-examine the physician's qualifications and that it has acted to recredential that physician.

Maintaining Standards for Medical Records

An accredited plan must set standards for medical record-keeping and have an established process for determining whether its physicians, who are managing its members' care, are meeting these standards. This typically means that a plan employee, often a nurse, will visit a physician's office and review a sample of medical records for plan members who have chosen that physician as their provider. The plan also must

have an established process to address physicians who do not meet the standards. Standards for medical record-keeping usually are provided in the plan's office manual, which the physician receives upon joining the plan.

Maintaining Member Satisfaction

As part of the accreditation process, a plan must survey its members annually to measure satisfaction with the care provided by physicians in the plan. A statistically significant sample of members are targeted to receive mail- or phone-based surveys, and results are reported on a plan-wide rather than physician-specific basis. The surveys ask questions about wait times, availability of appointments, ease of getting a referral believed necessary by the patient, and courtesy of the office staff. On an individual physician basis, the plan also must have an established process for investigating and resolving complaints by members against physicians who participate in the plan. Significant clinical issues may be reviewed by a committee of peers to determine whether action against the physician is necessary.

Supporting Quality Improvement Efforts

A critical criterion for accreditation is a plan's ability to demonstrate and document specific quality improvement activities that have resulted in improved health status of its members. The plan must be able to demonstrate that it measured results before it implemented an intervention and that it achieved improved results after the intervention.

For the practicing physician, this could mean being involved in a quality advisory committee that 1) identifies an area of concern (eg, low influenza immunization rates for high-risk members), 2) approves a set of guidelines (eg, Centers for Disease Control and Prevention immunization recommendations) for dissemination to members at risk and the physicians who treat them, and 3) reviews the results of the intervention. More indirectly, the practicing physician might receive the guidelines and list of members eligible for the intervention and be asked to reach out to patients who should receive the intervention.

Providing Preventive Care

Managed care has long stressed prevention of illness, and a plan's ability to demonstrate that its participating physicians actively practice preventive medicine is important for accreditation. Physicians regularly receive preventive service guidelines approved by the quality advisory committee of the plan's participating physicians, as well as physician and patient reminders of the need for preventive services (eg, Pap smears, child and adolescent immunizations, well-care visits). Through the standardized HEDIS® measures, all plans are required to report the results of their rates on several preventive health measures (*see* Table 2).

Physicians are involved in reporting these results in 2 ways: by providing the service and by documenting (in a claim or in the medical record) that the service was provided. Claims information is used annually to determine whether appropriate preventive services were provided to plan members. Thus, if a physician incorrectly codes for a well-child visit or never submits a claim for the service, the plan's reported rate of well-child visits may suffer, even though the service was provided. On a yearly basis, a physician may be selected to have his or her office records reviewed for additional evidence that specific services were provided. Medical record reviews are performed on a small sample of members, so that a physician will more than likely have only a few charts pulled for this review.

Managing Use of Resources

Health plans must submit quantitative information regarding the services provided to plan members, such as the number of hospital admissions, the number of hospital days, and the rates of specific procedures (eg, hysterectomy, coronary artery bypass surgery). Plans distribute guidelines on the medical appropriateness of specific procedures and may require prior approval of these procedures before they are performed. Physicians employed by the plan may discuss medical indications with the treating physician for services that he or she provides to patients enrolled in the health plan.

Physician Participation in NCQA

NCQA seeks input from practicing physicians through its Practicing Physicians Advisory Council, which suggests and reviews new standards and revisions to current standards. Physicians also participate as NCQA surveyors during on-site review of health plans. Finally, the ROC, which makes the final accreditation determination on each health plan, is composed exclusively of physicians.

The Future of Accreditation

Although efforts to accredit health plans are relatively advanced, considerable opportunity remains to expand the breadth and effectiveness of accreditation. To realize these opportunities, however, will require that several issues be addressed.

Making Provider Organizations Accountable

Public backlash against managed care has led to increased enrollment in preferred provider organizations (PPOs),

which have not had an opportunity for external evaluation of the quality of care and service they provide. As enrollment patterns shift, it is important to bring the advantages of evaluation and accountability to patients covered by all types of insurance arrangements. NCQA plans to develop mechanisms to evaluate physician organizations as well as continuing its current scope of evaluating health insurance plans. An accreditation program for PPOs is scheduled to launch in July 2000, which will focus on standards and CAHPS® survey results for the categories of Access and Service and Qualified Providers and will facilitate comparison of MCOs and PPOs in these areas.

Improving Performance Reporting

Health plan accreditation will become more comprehensive and more compelling as the health care industry develops better computerized information systems, allowing performance data to be more complete and accessible (with necessary patient protection) for measurement. Currently, most health plans must retrieve important clinical details about patient care from the paper-based medical record, a process that is time-consuming and costly to the health plan and ultimately limits the performance measurement process. Thus, many important outcomes and processes known to be associated with quality of care (eg, a foot examination in a diabetes patient) are not being measured because no easy procedure exists for documenting them in electronic databases from which they could easily be extracted. NCQA's Committee on Performance Measurement recently published several recommendations for improving health plans' capacity to electronically report performance data [11].

Coordinating Efforts Across the System

Performance measurement efforts need to be coordinated across levels of the health care system; otherwise, resources will be wasted and confusion may result. For example, the β-blocker measure described above may be viewed from the perspective of the hospital or the health plan; ideally, measurement activities should support both perspectives and, in doing so, should not create extra work.

In attempting to make performance results meaningful across levels of the system, NCQA, JCAHO, and the American Medical Association have formed a joint council to explore ways to reduce inefficiencies. Such collaboration creates the potential for a truly efficient measurement system, in which performance data are captured once but used over and over (to measure at different levels of the system). This collaboration also has the potential to send consistent signals about what is important to health plans, hospitals, and physicians. In doing so, all efforts would be focused on what is truly necessary for rapid quality improvement. And that is what ultimately matters.

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