

Getting the Best Out of Managed Care #2

Understanding Quality Measures



What can I learn from this fact sheet?

In order to figure out whether one health plan is better than another one, you need to have a way to measure each plan. In this fact sheet, you will learn what measurements are used to look at how well a health plan works.

Why is it important to understand quality measures?

If you understand the quality measures, the information can be more helpful to you.

For example, suppose you ask a friend to judge two soda drinks, A and B, which are in two different glasses. Your friend tries each drink and then tells you that soda B is better. What made your friend decide that B was better? Did it have more bubbles? Was it sweeter? Did your friend like B's color better? You would probably want to ask your friend why he thought that B was better. You would be asking your friend what *measures* he was using to decide that B was "better."

Let's suppose that your friend decided that B was better only because it was sweeter than A. If you do not like sweet drinks, then just knowing that B was "better" wasn't very helpful information to you. If you know what measures someone is using, then you can decide whether the results based on those measures are useful to you.

Knowing what measures are important to you applies in managed care quality information too. If you know what questions were asked and what

information was looked at, you could better decide what information works best for you.

Each person wants different quality information. Do you want to know whether the doctors' offices are accessible by wheelchairs? Is it important to know whether the doctors speak other languages? Would you want to know how long patients have to wait for appointments? Each person will answer these questions differently.

Tip: Why not make a list of the things about a health plan or about doctors that are important to you? As you read the information about quality, you can see better what types of measures *you* will want to look for.

Keep in mind: No measure of a health plan is perfect. Each measure has its problems.

You should look at several different performance measures that are important to you. A plan may perform well on some things and badly on other things. It's up to you to decide which measures are most important to you.

What should I know about standards of care?

For almost every medical condition, there is a generally accepted **standard of care** for people who have that condition. The standard of care is the yardstick that you can use to compare the care that your health plan offers with a level of care that is generally recommended or accepted. The standard of care may be developed by a group of specialists or by advocates for people with special needs.

A standard of care may recommend how often a person sees her doctor, what types of tests should be done, and what kind of training the health care provider should have to give this type of care.

Be the Smart Consumer: Do you know the standard of care for your child's special needs? If not, you may wish to contact the Title V agency near you or an advocacy agency for people with your child's particular needs. At the end of this fact sheet, there is information on contacting those agencies.

What are performance measures?

Performance measures show how well or how badly a health plan is providing quality services and meeting its goals. Performance measures are used for accreditation and for putting together report cards for the plans. Health plans use performance measures on themselves to see how well they are doing. Agencies that regulate or purchase services from health plans use performance measures to decide whether health plans are doing a good job.

What are the three main types of performance measures?

The three main types of performance measures are:

- Delivery system capacity;
- Process measures; and
- Outcome measures.

We'll explain each of them next.

What is "delivery system capacity?"

This performance measure looks at how well a health plan is able to handle all the people it is supposed to serve. This measure looks at things like:

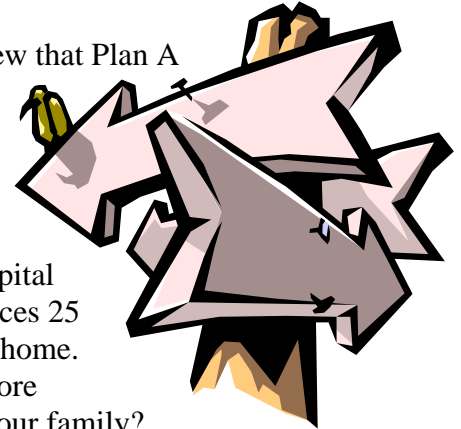
- How many patients per doctor?
- What kinds of doctors and specialists are in the plan's network?
- How well are the health care providers distributed around town?
- Do the doctors and the health care facilities offer services in other languages?

- Do the health care providers have proper training in what I need, including training in understanding other cultures?
- What is the most time and longest distance that the plan expects patients to travel for care?
- How long does a patient have to wait for an appointment?
- How often do the doctors in the plan join or leave the plan?
- Will my child have access to a pediatric special care center?

Why is delivery system capacity important?

Knowing about delivery system capacity can help answer some of the questions you may have about a plan. You could use this information to compare it to the same information from another plan.

Suppose you knew that Plan A has a hospital and doctors' offices only three miles from your home. Plan B has a hospital and doctors' offices 25 miles from your home. Which plan is more convenient for your family?



If your child has a chronic health problem or condition and needs a doctor who has experience in a special area of medicine, you would look at delivery system capacity to see if a plan has the health specialists that your child will need. If your child has special needs, she will need a pediatrician with the proper training.

Compare the delivery system capacity to the standard of care for your child's condition. If the standard of care requires that your child have access to a specialty care center, does the health plan include this option?

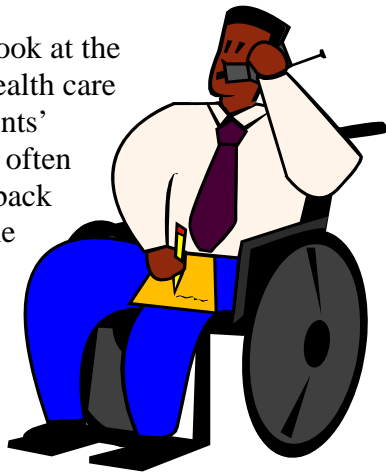
What are "process measures?"

Process measures look at what was done to care for the patient. These measures will look at how many visits patients have and the number of tests ordered for patients. Process measures include **utilization data** (how many times or how much the patients use the plan's services) and **encounter data** (how much service is provided to each individual member of the plan).

As an example, suppose you had diabetes. It is very important for people with diabetes to see their health care providers regularly and to have their kidneys, feet, and eyes examined each year. The health care provider should show them how to check their skin for problems. The performance measures for Plan A show that people with diabetes only see their doctors and have their eyes and kidneys tested once every two years. Patients in Plan B see their doctors and get these tests each year, and the health care providers are expected to show patients how to care for themselves at home. Which plan is going to give you better care for your diabetes?

What are "outcome measures?"

Outcome measures look at the results of the plan's health care services. Do the patients' lives get better? How often do people have to go back into the hospital for the same problem? Are people with chronic illnesses able to live independently or are they most often in an institution?



Outcomes measures look at whether the health care improves a person's life. For people with chronic illnesses, good outcome measures mean having a satisfactory or good quality of life.

How do performance measures work together?

Let's take the problem of childhood asthma. Asthma can be a difficult illness for children, and if it is not properly treated, can even lead to a child's death. We can take the three different kinds of performance measures to figure out how well a health plan deals with childhood asthma.

Does the health plan have enough pediatricians? If a health plan does not have enough doctors who specialize in children's health, then the plan does not have **delivery system capacity**.

How often do children with asthma see their doctors? If the children are not seeing their doctors regularly, then the plan may not be providing enough care to keep good track of the asthma. If the children are seeing their doctors too often, this would indicate that the health plan is not providing health education so that families can keep the asthma in control. **Process measures** that show too high or too low use of services could be problems. If you look at the standard of care for children with asthma, it will tell you how many visits to the doctor would be considered "normal." Of course, each person is different. But the health plan should compare well to the standard of care for asthma.

How well do the children with asthma live? If the children must constantly seek emergency care for their asthma, then the health plan would have poor **outcome measures**.

What are the problems with performance measures?

There are several things that you will want to keep in mind when you are looking at performance measures.

Most process and outcome measures only look at what happens to patients who have been in the plan at least one year. People who leave the plan in less than a year do not get included. Also, people who

are only enrolled for a short time, like many people on Medicaid, are not included.

Because the information is so complicated, it sometimes takes two or three years to put the information together. Look at the year that the information was collected. A plan can make big improvements or get a lot worse in two or three years time.

The information may not be complete. If a person receives health care outside of the plan, this health care will not be included in the plan's measures. If someone needs to get care from a specialist that is not in the plan's network, this care will not show up in the measures.

Performance measures may only be collected for certain areas of service. A health plan may concentrate on making those areas look good. If a health plan knows that someone is only going to measure how well it serves people with diabetes, then the plan may work harder with those patients with diabetes. Those performance measures will not tell you how well the plan serves people with heart problems or mental health needs.

Who puts the performance measures together?

There are a couple of organizations that put this information together.



As mentioned in Fact Sheet #1, NCQA uses HEDIS to measure performance. Many health plans, state agencies, and employer groups use HEDIS standards to compare health plans.

The Child and Adolescent Health Measurement Initiative (CAHMI), originally developed at the

Foundation for Accountability (FACCT), is a set of consumer-centered quality measurement tools. CAHMI is now a project at the Oregon Health & Science University. Some of the CAHMI measures are included in CAHPS surveys and HEDIS. Some health plans use the CAHMI measures to look at their own services.

The Agency for Healthcare Research and Quality (AHRQ)



also has developed the Consumer Assessment of Health Plans (CAHPS) survey. This survey is given to members of health plans to get their opinions about their health care providers and the care that they receive. Fact sheet #5 tells more about consumer surveys like CAHPS

Where can I get the results of these measures?

The HEDIS measures are put together in NCQA's *Quality Compass* and the *Health Plan Report Card*. The Pacific Business Group on Health uses HEDIS for its *HealthScope*. Some state health departments and Medicaid agencies use HEDIS measures and may have report cards using the measures. CMS requires HEDIS measures for all Medicare managed care health plans. See the end of this Fact Sheet to find out how you can get this information.

You can find links on this fact sheet and the other fact sheets in this series to many Web sites where you can see the results of these measures. State Web sites provide the information for free. Some other Web sites or companies may charge you for the results. You may also want to ask your health plan for the results of their performance measures.

What is enrollment and disenrollment information?

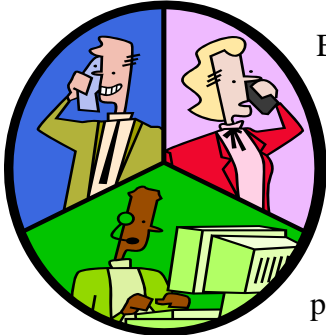
Enrollment information counts how many people are in a health plan and how many new people join the health plan. Enrollment information will

include people who join the plan by default or automatic enrollment. (See Fact Sheet #1)

Disenrollment information looks at how many people leave a plan. Sometimes the information tells you why the people left the plan. Disenrollment can be voluntary, maybe because a person did not like the health plan. Disenrollment can also be mandatory. If a person's employer no longer offers the health plan or a person is no longer eligible for Medicaid, then the health plan will disenroll the person.

Why is enrollment information helpful?

Enrollment information can tell you how many people are in a plan. The number of people in the plan is good to know when you are looking at other performance measures. If a plan has 100,000 members and 100 leave, that is less than 1% of the people leaving the plan. But if the plan has 1,000 members and 100 leave, the plan lost 10% of its members, and that can indicate problems.



Enrollment information can tell you whether people are joining the plan. If a lot of people are joining the plan, it could be because they have heard good things about the plan.

This information can also tell you who is enrolling in the health plan. Are other people with special needs enrolling in the plan? Is the plan only enrolling younger, healthier people? If so, the plan may be trying to get only people who don't use many services. This could be a warning sign for someone who has special needs and will need regular or frequent services.

If the plan has lots of members but few health care providers, you may have to wait a long time to get appointments.

Why is disenrollment information important?

If a lot of people are leaving a health plan, it could show that the plan is not providing services well. Maybe the quality of care is not good. Maybe the health plan does not have offices in convenient locations.

Look at who is leaving the plan. Are people with special needs leaving? If so, the health plan may not be providing the services that these patients need. Right now, it can be difficult to find out exactly who is leaving a plan, but that information may become more available in the future.

It is important to separate the voluntary disenrollments from the mandatory ones. Mandatory disenrollment numbers may not say much about the quality of the health plan. Voluntary disenrollment numbers will probably tell you more about quality.

When you look at disenrollment numbers, also keep in mind what the health plan market is like in your area. If there are lots of choices in your area, the health plans may have higher disenrollment numbers because there are more choices. Newer health plans may have higher rates of disenrollment than older health plans that already have a well-known reputation in the community.

Where can I get enrollment and disenrollment information?

Some employer groups, such as the Pacific Business Group on Health, include this information in their annual report cards.

HEDIS includes disenrollment as one of the measures. Reports that use HEDIS measures may include disenrollment information. However, the HEDIS measure will not tell you whether the disenrollment was voluntary or mandatory.

If your state has an agency that regulates managed care plans, the agency may have enrollment

information for each health plan. You also can ask a health plan directly for enrollment and disenrollment information.

Some consumer advocacy organizations have enrollment and disenrollment information.

What are grievances and complaints?

Many health plans use these two terms to mean the same thing. However, here we will try to separate the terms.



A **grievance** is a protest that you make against your health plan. If you are unhappy with the health care services or do not get services that you think that you should get, you would file a grievance with the health plan. A grievance is usually

in writing. The health plan will review the grievance and decide

what to do. What counts as a formal grievance and the process for handling grievances varies a lot from state to state and from one plan to another.

A **complaint** is a protest that you file with an agency outside of the managed care health plan. You might file a complaint with the state agency that regulates health plans. CMS has a contract with the Maximus/Center for Health Dispute Resolution to handle complaints about Medicare managed care health plans. The U.S. Department of Labor can take complaints about certain other types of health plans. In most states, there is an agency like the department of corporations, department of health or department of insurance where you can file a complaint about a health plan.

Be the Smart Consumer: If you want to file a grievance against your health plan, always read your benefits booklet carefully to see how the plan's grievance process works.

Why is the number of grievances and complaints useful information?

If a health plan has a lot of grievances or complaints against it, that could indicate that the plan is not delivering services very well. You should always compare the rate of grievances against the rate of grievances at other plans so you can figure out what is a high or low number.

A low rate of grievances may indicate that members of the plan are happy with the services. However, this is not always true. If a plan does not do a good job of telling its members how to file grievances, then, of course, the plan will have a low number of grievances. A plan that does a good job of telling its members how to file grievances and has an easy grievance process will have more grievances, but it might be giving care that is just as good as the plan with fewer grievances.

Be the Smart Consumer: Try to find out the reasons for people's grievances. Were people grieving something important to you? Can you tell whether the plan has improved after getting grievances?



What are some problems with this complaint and grievance information?

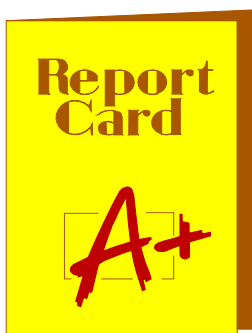
There is no standard for how this information is collected. Some plans may call everything "complaints," so the plans will show that they have no grievances. Each plan also decides what to call the categories for complaints. This makes it hard to compare one health plan's grievances with another one's.

A larger health plan has more members. With more members, the plan may also have more grievances. Therefore, if you see that a plan has a lot of grievances, also look to see how large the plan is.

Where can I get information on the numbers of grievances and complaints?

If your state's agency that regulates health care plans collects quality information, that agency may have information about grievances and complaints against health plans. If your state requires health plans to keep track of these numbers, you should be able to get the information from the health plans too.

NCQA also collects information about grievances and complaints. NCQA does not collect the number or types of grievances or complaints. However, NCQA does look at how plans tell their members about the grievance process and how well plans respond to patient satisfaction ratings.



How do quality measures apply to report cards and consumer surveys?

The quality measures described in this fact sheet are the basis for most report cards. The quality measures provide most of the objective information for report cards and studies of managed care. These measures provide numbers, rather than patients' opinions, to give a picture of how well a plan is doing. Consumer surveys provide subjective information—opinions, feelings, and experiences of patients in the managed care plans. Both sets of information are extremely important for looking at the quality of managed care.

Do quality measures tell me all I need to know about the quality of care?

Quality information does not measure a lot of things that may be important to many consumers. Sometimes even if you have all the quality information available, there may be issues or questions unanswered. For those unanswered questions, you may want to talk to friends in the

same health plan or talk directly to the doctor or the health plan.

Quality information will not always tell you how patients get health care after business hours. Through your own experience, you will know whether you can really talk with the doctor and whether she listens to you. You will probably need to ask the plan directly to find out whether transportation to services is offered. You will have to look at the plan's list of providers to know whether many doctors even accept the health plan.

Making Contact:

Standards of Care: To find out the standard of care for a particular illness or condition, you might wish to contact an agency that advocates for people with that special need. Groups like the American Diabetes Association, the American Heart Association, or Family Voices are examples of these agencies. Some of these agencies are local; some are nationwide.

For the standard of care for a child's illness or condition, contact your local Title V (Maternal and Child Health Access Agency). To find the agency for your state or local area: Go to https://perfdata.hrsa.gov/mchb/mchreports/link/state_links.asp.

To see performance measures on plans: Contact the plan's **Member Services** office directly. Ask for copies of performance evaluations that the plan has conducted most recently.

Contact the agency in your state that regulates managed care plans. The agency may be called something like the department of corporations, department of insurance, department of health, or department of managed care. Ask for copies of any measures of performance, especially audits and reviews which the agency may have for the plan you are looking at.

NCQA

1100 13th St., NW, Suite 1000
Washington, DC 20005
(202) 955-3500
www.ncqa.org

Medicare Personal Plan Finder

1-800-633-4227 (Medicare Hotline)
1-800-MEDICARE
www.medicare.gov/MPPF

This federal Web site can help you find and compare Medicare managed care plans and Medicare supplemental plans in your area.

AHRQ

National Guidelines Clearinghouse
P.O. Box 8547
Silver Spring, MD 20907-8547
1-800-358-9295
1-888-586-6340 TDD
www.guidelines.gov

The Web site has information on the standards of care for many diseases and conditions. You can also take a look at the Child Health Care Quality Toolbox at:

www.ahrq.gov/chtoolbox/

AHRQ's "Your Guide to Choosing Quality Health Care" is helpful for understanding health care quality. It is available at:

www.ahrq.gov/consumer/qnt/

CAHMI

The Child and Adolescent Health Measurement Initiative
503-494-1930

www.cahmi.org

CAHMI has quality measurements specific to children with special needs. It is a project of the Department of Pediatrics, School of Medicine, Oregon Health & Science University.

AARP

601 E St. NW
Washington, DC 20049
1-888-687-2277

AARP also has chapters in many states.

www.aarp.org

The Web site also has information about health insurance options for adults.

National Business Coalition on Health

1015 18th Street N.W., Suite 730
Washington, DC 20036
(202) 775-9300
www.nbch.org

There are business groups on health in many areas of the country. Many are members of the National Business Coalition on Health. To find the one in your area, go to the Web site and look under "Coalition Members". Some of the Web sites have consumer-friendly information for comparing health plans. If not, you still might share the information with your employer.

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Fact Sheet #2 is one of five fact sheets on managed care for consumers. If you have trouble finding copies of the other fact sheets, please visit the National Health Law Program's Web site at: <http://www.healthlaw.org/link.cfm?7727> to download your free copies.

National Health Law Program 2008

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