

**GETTING BEHIND THE NUMBERS:
UNDERSTANDING PATIENTS'
ASSESSMENTS OF MANAGED CARE**

Margaret Gerteis, Teresa Harrison, Cara V. James,
Michael Manocchia, Fiona Smith, & Susan Edgman-Levitan
The Picker Institute

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EXECUTIVE SUMMARY

Studies of public perceptions of managed care, patient experiences with the system, and physicians' attitudes toward it reveal serious and growing concerns about the way managed care will affect the present and future of the U.S. health care system. Clinicians and patients alike worry about constraints on the time and quality of patient-physician interactions, about reduced access to needed services and treatments, and about the loss of control over fundamental clinical decisions. However, some managed care plans work better than others, from the point of view of the patients they serve. The term "patient-centered" refers here to practices that address patients' needs and concerns, as patients define them. If managed care is to survive and meet the health needs of the nation, it is critical to identify, understand, and build on those attributes of the system that contribute to sustainable positive performance.

The study described here, supported by The Commonwealth Fund and conducted by staff from The Picker Institute, set out to identify plan-level practices that contribute to a positive experience for plan members. Using data from the Medicare Managed Care Consumer Assessment of Health Plans Survey (MMC-CAHPS[®]), we identified and visited nine plans with different patterns of performance operating in five geographic markets.

Although health plans' operating strategies varied widely by market area, and many different factors affected specific CAHPS[®] scores, we identified several discretionary plan practices that enhanced both members' experiences with the plan's benefits and services and their clinical interactions with caregivers. In addition, we found health plans that demonstrate a long-term commitment to patient-centered performance shared strategies that include the identification of members as the plan's primary customers and the incorporation of member satisfaction into integrated measures of quality.

STUDY METHODOLOGY

The Medicare Managed Care CAHPS questionnaire contains questions that relate to beneficiaries' experiences with providers, providers' office procedures, and with the health plan in which they are enrolled. For purposes of scoring and reporting, the questions are organized into five composites:

- getting care quickly
- getting needed care
- doctors who communicate well

- courteous and helpful office staff, and
- plan-level customer service.

Drawing on the first wave of MMC-CAHPS data as well as other data on plan performance, we identified and visited both higher-performing and lower-performing plans within selected geographic markets. We sought to distinguish discrete organizational features and practices that contribute to plan performance from common environmental factors that might account for variations in survey results. Each site visit lasted for 1½ to 2 days and was conducted by a team of two or three researchers, including senior investigators. Site-visit team members conducted one-on-one and group interviews with senior plan officials, medical directors, selected providers, and directors in charge of Medicare contracting, marketing, provider relations, and member services. To guide our investigation, we developed and followed a set of protocols designed to reveal factors that influence plan performance on the CAHPS dimensions.

The selected plans exhibited the following characteristics:

- *Profit status*
 - 2 for-profit
 - 7 not-for-profit
- *Markets*
 - New England (2)
 - Dade County, Florida (2)
 - Southern California (2)
 - Alabama (1)
 - Pacific Northwest (2)
- *Model/type*
 - network/IPA (4)
 - group/network (3)
 - PHO (1)
 - staff (1)
- *Enrollment*
 - 100,000–200,000 (4)
 - 400,000–650,000 (3)
 - > 1,000,000 (2)

- *Mean AAPCC*
 - < \$250 per member per month (2)
 - \$250–\$300 (2)
 - \$300–\$350 (3)
 - \$350–\$400 (2)

FINDINGS: PLAN-LEVEL PRACTICES THAT AFFECT PERFORMANCE ON CAHPS DIMENSIONS

We did not find a one-to-one correspondence between specific CAHPS scores and discretionary plan-level practices that “explained” those scores among the plans we visited. However, we identified several discretionary practices that contributed to improved or sustained performance within each CAHPS dimension. These practices affected the quality of members’ experiences with benefits and services administered directly by the plan as well as with clinicians and clinicians’ offices.

1. **Getting care quickly.** Plan performance on this dimension depended largely on practices within medical offices or medical groups and on the overall supply of providers in the local market. However, plan-level practices designed to improve physicians’ or medical groups’ performance on these measures include:
 - plan-sponsored training for physicians’ office staff on appointment scheduling systems and telephone triage protocols; and
 - the use of performance-tracking criteria that reflect members’ expectations about access and timeliness, rather than administrative measures alone.

2. **Getting needed care.** Plans’ performance on questions related to this dimension reflected market conditions and plans’ overall strategies for managing care as well as specific operating practices. For example, some high-scoring plans that operate in markets where physicians were unaccustomed to a high degree of managed care oversight did little to hold physicians accountable for costs associated with referrals; it seems likely that patients perceived very little difference in practice between this type of managed care and standard fee-for-service insurance coverage. The performance of plans that delegated utilization and care management functions to intermediaries may be as much a function of practices undertaken by the risk-bearing entities as of plan practices, per se. Several plans also attributed lower scores on these measures to local shortages of specialists or ancillary care providers.

Specific plan-level operating practices that contribute to higher performance on these measures include:

- educating prospective members up front about the scope and limitations of covered benefits, referral policies, and procedures for obtaining necessary approvals;
 - building on established referral networks when creating provider panels, in order to limit the perceived need for out-of-network referrals;
 - expediting referrals for routine preventive care or established diagnoses, especially for chronic conditions; and
 - empowering staff to resolve problems in the first instance and to take patients out of the middle of disputes about covered benefits or services.
3. **Doctors who communicate well.** These measures assess members' perceptions of their direct interactions with the plans' health care providers. Plan-level practices designed to improve physicians' or medical groups' performance on these measures include:
- recruiting doctors known for their ability to communicate well with patients;
 - providing physicians with feedback on their performance, and offering them training to improve communication;
 - encouraging the use of scheduling protocols that eliminate inflexible appointment slots; and
 - the use of clinical practice guidelines that incorporate shared decision-making cues and protocols.
4. **Courteous and helpful office staff.** Questions on this dimension assess members' perceptions of their interactions with staff at clinical sites. Plan-level practices aimed at improving member satisfaction with clinical office staff performance include:
- providing feedback on patient satisfaction by clinical site;
 - plan-sponsored training in service quality to physicians' office staff; and
 - providing direct customer-service support at clinical sites, so that members' questions about plan coverage, policies, and procedures are answered at the point of service, where they most often arise.
5. **Plan-level customer service.** One of the most striking findings of the study was the extent to which all of the participating plans had invested in customer service, especially for Medicare members. In some of the higher-performing plans, this practice represented a long-term commitment. In lower-scoring plans, the investment was often more recent, a deliberate response to identified problems.

Some noteworthy practices designed to enhance plan customer service include:

- the coordination of marketing with customer-service functions, often based on a one-on-one relationship between sales representatives and prospective members;
- the training of product-specific customer-service teams, especially for Medicare products, which gave plan members immediate access to customer-service representatives knowledgeable about their product;
- the use of integrated information systems to support customer-service functions, which gave customer-service representatives immediate access to information on the status of claims, complaints, or grievances; and
- direct outreach to members through public meetings, report cards on participating providers, and other communications mechanisms.

DISCUSSION: FACTORS THAT AFFECT PLAN OPERATIONS AND CAHPS PERFORMANCE

One of the challenges the study team faced was distinguishing which of the factors that shape members' perceptions of plan performance could be affected or altered through discretionary plan practices.

Although CAHPS survey respondents are asked to distinguish between encounters with clinicians and encounters with the plan, our field investigations suggest that plan members have little understanding of the divisions of responsibility for decision-making, assumption of risk, or other matters relating to managed care operations. Therefore, they may attribute to the plan decisions or behaviors that are actually made by clinicians, and vice-versa. In addition, CAHPS survey results reflect performance at a given point in time. Low scores did not necessarily reflect sustained poor performance, nor did high scores necessarily reflect sustainable good performance.

We posited that a variety of characteristics relating to a plan's environment, history, mission, ownership, structure, and governance would affect its performance on the CAHPS survey, either because they shape the plan's strategy and operations or because they independently shape members' perceptions and experiences. We found the environment of local markets to be even more important in understanding differences in plan practices and performance than we anticipated. Moreover, statistics on managed care market penetration revealed little about the "maturity" of any given market. Instead, a number of factors contributed to the managed care environments of the sites visited. These included the degree of integration of the principal health care delivery systems in the market area, the history of third-party constraints on health care costs, the professional

culture of practicing physicians, the history of managed care in the area, and managed care penetration.

Other findings were contrary to our expectations. Observed differences in history, mission, and organizational culture did not translate into differences in members' perceptions of plan performance, as reflected in CAHPS survey scores. Moreover, profit status alone told us little about a plan's operations, given the observed complexities of corporate structure. A demonstrated commitment to population management was not associated with higher CAHPS scores, contrary to expectations.

Providers played an active role in the governance of several participating plans, but this involvement did not appear to relate to performance on CAHPS measures. The ways physicians were paid varied with market characteristics (with some form of discounted fee-for-service prevailing in the less-mature markets), but this did not appear to be related to CAHPS scores at participating plans. CAHPS performance among plans that offer incentives to physicians also varied, suggesting that other factors affected consumers' perceptions of physicians.

Consumer involvement in governance and policy-making, which was less in evidence, appeared to have no substantive effect on plan operations or on CAHPS measures of performance.

STRATEGIES SUPPORTING PATIENT-CENTERED PERFORMANCE

The study team identified several crosscutting strategies essential to developing and sustaining patient-centered practices in managed care over the long term.

1. Identifying plan members as the plan's primary customers. One of the most compelling insights to be gleaned from the higher-performing plans was their discovery that to successfully compete for Medicare business, they must understand market demographics and the specific needs of the elderly, and take a one-on-one approach to marketing to individual Medicare beneficiaries. This contrasts sharply with the approach usually taken on the commercial side of the business, where purchasers (employers, benefits managers, brokers) rather than individual consumers are the primary customers, and where relatively little is known about the end users. Some plans are beginning to apply the lessons learned from Medicare to the commercial side of the business by finding ways to reach out to members directly.

2. **Managing consumers' expectations.** High-performing plans invested heavily in informing members about plan operations, benefits, and service both before and immediately after enrollment. This was particularly true for targeted Medicare beneficiaries, who were identified as especially savvy consumers, but several plans extended the practice to commercial members, as well.
3. **Recognizing and managing consumers' perceptions of plan and provider responsibilities.** Several of the plans participating in the study were sensitive to the potential for confusion and misunderstanding about the division of responsibility between plans and providers. This yielded two different strategies for managing consumers' perceptions. The more common strategy was to keep the plan's involvement in clinical decisions or clinical practice as invisible to members as possible, recognizing that members look to caregivers, not to health plans, on clinical matters. A far less common, but emerging, strategy was to reach out directly to members in an effort to enhance the plan's visibility as an active promoter of clinical quality. This entailed giving information about clinical guidelines, treatment options, and providers' quality performance to consumers.
4. **Incorporating members' perceptions in quality measures and improvement strategies.** All of the plans that participated in the study were involved to some degree in the measurement of quality performance and member satisfaction. The most effective practices, however, entailed routinely gathering information experiences at a variety of levels and from a variety of sources on past, present, and potential members' perceptions. Better-performing plans also had well-established procedures for feeding this information to plan-wide strategic planning and quality improvement committees, who used it to identify priorities and to establish continuing performance measures. The plans also used the information to give contracting physicians or medical groups routine feedback about their performance.
5. **Linking providers' incentives to patients' reported experiences.** Among the plans that routinely tracked physicians' performance on quality measures (including patient satisfaction and service quality), the use of financial incentives to improve performance elicited a mixed response. Where financial rewards for performance were offered, physicians commented that although the dollar amount was not large, the incentive sent the message that the plan cared as much about quality as it did about costs. One plan was philosophically opposed to rewarding physicians financially for what it thought ought to be a routine part of practice. However, the plan did give medical groups feedback about their physicians'

performance, provided training and education on the “art of caring,” and required corrective plans of action as part of its contract negotiations.

CONCLUSION

Although this study was limited to observations about performance in only nine managed care plans, our findings suggest that researchers and policy analysts should be cautious when interpreting aggregate performance measures based on disparate plans and markets, and in using such data to identify benchmark performance.

Notwithstanding the limitations of the study, we identified discretionary practices at the plan level that contribute to members’ positive experiences with managed care. We also found that plans poised to sustain superior performance share a strategic focus on the individual plan member as the primary plan customer; a recognition that members’ subjective experiences are integral to the quality of care; a commitment to quality assessment and improvement that incorporates measures of members’ perceptions and experiences; and a relationship with providers that reinforces a commitment to this conception of quality.

GETTING BEHIND THE NUMBERS: UNDERSTANDING PATIENTS' ASSESSMENTS OF MANAGED CARE

INTRODUCTION

Studies of public perceptions about managed care, patient experiences with the system, and physician attitudes toward it reveal serious and growing concerns about how managed care will affect the present and future of the U.S. health care system.¹ Clinicians and patients alike worry about constraints on the time and quality of patient-physician interactions, about reduced access to needed services and treatments, and about the loss of control over fundamental clinical decisions. Notwithstanding these concerns, some managed care plans clearly work better than others, from the points of view of the patients they serve and the clinicians who work in them. The term "patient-centered" refers here to practices that address patients' needs and concerns, as patients define them. If managed care is to survive and meet the health needs of the nation, it is critical to understand and build on those attributes that contribute to sustainable positive performance while remaining consistent with managed care's mission of creating a more rational, equitable, and efficient health care system.

The study reported here set out to investigate managed care plans' performance from the point of view of their members in order to gain insight into the factors that affect members' perceptions about the plan, and to identify plan-level practices that contribute to a positive experience. With grant support from The Commonwealth Fund, staff of The Picker Institute conducted a field study of nine selected managed care plans that participate in the federal Medicare program. The study lasted from June 1998 through September 1999.

I. STUDY OVERVIEW

The Picker Institute is a nonprofit health care research and consulting firm in Boston, Massachusetts. It has developed a conceptual framework for understanding patient-centered care and tools to assess the quality of patients' experiences in a variety of inpatient

¹ American Hospital Association (AHA), "Reality Check: Public Perceptions of Health Care and Hospitals," (Washington, DC: 1996); "Eye on Patients: A Report from the American Hospital Association and the Picker Institute," January 1997; David Mechanic, "The Impact of Managed Care on Patients' Trust in Medical Care and Their Physicians," *Journal of the American Medical Association* 275 (1996):1693-1697; National Coalition on Health Care, "How Americans Perceive the Health Care System," A Report on a National Survey Conducted by International Communications Research, January 1997; David H. Thom and Bruce Campbell, "Patient-Physician Trust: An Exploratory Study," *The Journal of Family Practice* 44 (1997):169-176.

and ambulatory clinical settings.² Working with the Consumer Assessment of Health Plans Study (CAHPS), the institute also participated in the development of a survey instrument that assesses the performance of health plans in areas that matter most to consumers. The CAHPS products were designed for use with all types of health-insurance consumers (Medicaid recipients, Medicare beneficiaries, and those who are commercially insured) and across the full range of health care delivery systems. The Health Care Financing Administration is now using the CAHPS instrument to assess beneficiaries' experiences with Medicare managed care plans, providing the first standardized national comparative database of health-plan performance from the members' perspective.

The Medicare Managed Care-CAHPS questionnaire contains questions that relate to the quality of beneficiaries' experiences with providers, providers' office procedures, and with the health plan in which they are enrolled. For purposes of scoring and reporting, survey questions are organized into five composites:

- getting care quickly
- getting needed care
- doctors who communicate well
- courteous and helpful office staff, and
- plan-level customer service.³

The survey also includes four rating items: overall rating of health plan, overall rating of health care, overall rating of personal doctor, and overall rating of specialists. The MMC-CAHPS survey contains items specific to the Medicare population, including questions that relate to care for common chronic illnesses.

Drawing on the first wave of MMC-CAHPS data⁴ as well as other data on plan performance, Picker Institute project staff identified and visited both higher-performing

² Paul D. Cleary, Susan Edgman-Levitan, Marc J. Roberts et al., "Patients Evaluate Their Hospital Care: A National Survey," *Health Affairs* 10 (1991):254-267; Margaret Gerteis, Susan Edgman-Levitan, Jennifer Daley, and Thomas L. Delbanco, *Through the Patient's Eyes: Understanding and Promoting Patient-Centered Care* (San Francisco: Jossey-Bass Publishers, 1993).

³ A listing of specific CAHPS questions relating to each of these dimensions is included in Appendix 1.

⁴ Data was gathered by the Health Care Financing Administration for all participating Medicare managed care plans in 1997, and reported in 1998. Analysis of the Medicare CAHPS data used for this project was conducted by a team of researchers from Harvard Medical School, led by Paul D. Cleary, Ph.D.

and lower-performing plans within selected geographic markets. They sought to distinguish the organizational features and practices that contribute to plan performance from common environmental factors that might account for variations in survey results. Each site visit lasted for 1 1/2 to 2 days and was conducted by a team of two or three researchers, including senior investigators. Site-visit team members conducted one-on-one and group interviews with senior plan officials, plan medical directors, selected providers, and directors in charge of Medicare contracting, marketing, provider relations, and member services.

The study team followed a set of protocols designed to probe factors that might influence plan performance in areas related to the CAHPS dimensions. Areas of focus included environmental factors such as the regulatory environment and market characteristics; organizational characteristics including plan history and mission and plan structure and governance; and specific plan operating strategies, including community initiatives, relations with employers and purchasers, relations with providers, and relations with Medicare beneficiaries.⁵

Table 1, below, is a descriptive summary of the nine plans participating in the study and their performance on the MMC-CAHPS survey.

Table 1. Descriptive Summary of Plans Visited

Plan	Market Area	Profit Status	Model/Type	Estimated Enrollment	Mean AAPCC*	Plan Rating**
A	Alabama	For-profit	IPA and network	160,000	\$331	64
B	New England	Nonprofit	Group and network	185,000	\$299	69
C	New England	Nonprofit	IPA and network	600,000	\$299	63
D	Florida	Nonprofit	Network	530,000	\$384	58
E	Florida	Nonprofit	PHO and network	135,000	\$384	69
F	Southern California	Nonprofit	Group	>1 million	\$307	45
G	Southern California	For-profit	Group and network	>1 million	\$307	45
H	Pacific Northwest	Nonprofit	Staff and network	400,000	\$230	50
I	Pacific Northwest	Nonprofit	Network and IPA	500,000	\$220	50

* Adjusted Average Per Capita Costs (AAPCCs) shown here are the capitated monthly payment rate for Medicare Part A, Aged, only, averaged over the counties served for each plan.

** Numbers shown represent the percentage of respondents rating the plan "excellent."

II. FACTORS THAT AFFECT PLAN PERFORMANCE ON CAHPS DIMENSIONS

One of the major challenges the study team faced was to sort out the factors that shape members' perceptions of plan performance (as captured on the MMC-CAHPS survey).

⁵ Study protocols are included in Appendix 2.

Uncovering such factors helps to identify discretionary operational practices at the plan level that contribute to members' perceptions and experiences.

For example, the CAHPS survey is designed to elicit information about members' interactions with individual providers or clinical services and about their experiences with health-plan representatives, programs, and services. Recent analyses of MMC-CAHPS data confirm that survey respondents do distinguish between encounters with clinicians and encounters with the plan.⁶ However, the field investigations conducted for this study suggest that plan members have little understanding of how responsibility for decision-making, assumption of risk, or other matters relating to managed care operations is divided between clinicians and the plans. Members' perceptions of plan-level and provider-level responsibilities may be particularly confused when intermediaries (such as IPAs or medical groups) are involved. Therefore, patients may attribute to the plan decisions or behaviors that are actually made by clinicians (e.g., decisions regarding referrals or covered services). They may also attribute to clinicians actions that were in fact initiated by the plan (e.g., clinical outreach related to case management and care management activities).

Market characteristics and the overall environment of managed care within different markets turned out to be more important to an understanding of the differences in plan practices and performance than the study team had anticipated. The environment of managed care in each of the markets visited shaped the expectations that patients and physicians brought to their relationships with one another and that each brought to their relationships with the plan.⁷ Market characteristics also clearly shaped the strategic options and practices that plans could pursue to manage care and their relationships with providers and beneficiaries. In other words, the strategies and practices that worked in some environments would probably not work in others.

In addition, CAHPS survey results are a snapshot of plan performance at a given point in time. The study team found that, overall, CAHPS scores were consistent with participating plans' own assessments of their strengths and weaknesses at the time the surveys were conducted. However, low CAHPS scores did not necessarily reflect sustained poor performance, nor did high scores necessarily reflect sustainable good performance. In some cases, relatively poorer scores on specific questions or dimensions reflected transient difficulties (e.g., an increased demand on customer service because of a

⁶ Alan M. Zaslavsky, Nancy Dean Beaulieu, Bruce E. Landon, and Paul D. Cleary, "Dimensions of Consumer-Assessed Quality of Medicare Managed Care Health Plans," *Medical Care* 38 (February 2000):162-174.

⁷ This is consistent with findings reported by Randall S. Brown and Marsha R. Gold, "What Drives Medicare Managed Care Growth," *Health Affairs* 18 (November/December 1999):140-149.

sudden influx of new members or a recent change in benefits) which the plans were effectively addressing. In other cases, higher scores reflected policies and practices that clearly were not financially sustainable.

In sum, there was no one-to-one correspondence between CAHPS scores on a given dimension and identified plan-level practices that “explained” those scores. The study team’s task, then, was to understand the factors that contributed to plan performance and to identify practices that held promise to improve the quality of members’ perceptions and experiences or sustain them over time.

Following is a brief discussion of the major factors that affect performance in a given CAHPS dimension. This is followed by more a detailed discussion of effective plan-level practices that contribute to improved or sustained performance within that dimension.

Getting Care Quickly

CAHPS questions that relate to getting care quickly cover telephone and personal access to health care professionals, appointment scheduling, and waits in the clinic or doctor’s office (Appendix 1). In general, the way plans performed on these questions depended on practices within medical offices or medical groups (e.g., scheduling protocols or telephone triage systems), rather than on specific plan-level practices. Plans that tracked provider performance on these measures reported wide variation from one practice to another.

Plans that operate in markets with an oversupply of providers (e.g., Alabama and Florida) often cited market conditions to explain high scores on CAHPS questions relating to access and ease of scheduling appointments. However, one plan in these markets that exhibited markedly lower scores on questions related to getting care quickly actively restricted the number of providers in its networks in an effort to control costs. This suggests that plan-level policies could affect members’ perceptions adversely regardless of favorable market conditions.

- | Getting Care Quickly |
|--|
| <ul style="list-style-type: none">• Offer plan-sponsored training on appointment scheduling systems and telephone triage protocols for physicians’ office staff• Use criteria that reflect members’ expectations regarding access and timeliness when tracking performance, rather than administrative measures alone |

Noteworthy plan-level practices designed to improve physicians’ or medical groups’ performance on these measures include:

- Plan-sponsored training for physicians' office staff. Although Medicare CAHPS data does not provide information about the performance of specific clinical sites, several plans used measures of their own to track the performance of contracting physicians or medical groups on questions relating to patient access. This allowed them to identify practice sites with problems, as well as those that performed exceptionally well. One plan noted that problems often arose in smaller practice sites where there was little administrative support or expertise. The plan therefore offered on-site training to physicians' office staff on appointment scheduling and telephone triage. Several plans also sponsored workshops and seminars that encouraged workers from different medical offices to share information about their practices.
- Tracking provider performance against members' criteria for access and timeliness. Clinical practices often use administrative statistics to track performance on access (e.g., data on next-available-appointment, telephone-call response times, or call-abandonment rates). While such data can be useful to track performance trends, they may offer little insight into patients' or plan members' perceptions about timeliness.

One plan noted a discrepancy between administrative measures of access, which suggested that practice sites were performing quite well, and patient satisfaction data, which suggested otherwise. Plan staff convened member focus groups to investigate the discrepancy and discovered that members' understanding of "urgent" and "routine" needs for care were very different from providers'. Specifically, patients defined "urgent" as anything that was symptomatic. Since they had usually been experiencing symptoms for some time before they called, they expected to be able to see their caregivers fairly quickly. Providers, on the other hand, defined "urgent" to apply only to the more serious ailments, relegating the more common complaints (however bothersome they may be to patients) to the "routine" category, where waits for appointments were longer. The plan began using members' definitions and tracked performance against members' expectations.

Getting Needed Care

CAHPS questions for this dimension address ease of finding a primary care provider, access to specialists, and ease of referrals for special tests or treatment (Appendix 1). Participating plans' performance on questions relating to this CAHPS dimension reflected market conditions and plans' overall strategies for managing care as well as specific operating practices.

Two plans with higher scores on questions relating to ease of referrals and access to tests and treatments admittedly did little in the way of utilization review or management and little to hold physicians accountable for costs associated with referrals. Both these plans operate in markets where physicians were unaccustomed to a high degree of managed care oversight (and where AAPCCs were traditionally high). In both plans, physicians had, in the past, been paid primarily on a discounted fee-for-service basis, and it seems likely that patients perceived very little difference in practice between this type of managed care and standard fee-for-service insurance coverage. However, both plans were in states of transition, and it remains to be seen whether either plan can sustain high CAHPS scores after these shifts in strategy have taken effect.

Performance on this CAHPS dimension may be as much, or more, a function of practices undertaken by the risk-bearing entities than of plan practices per se in plans that do transfer risk and delegate utilization and care management functions to IPAs, medical groups, or other intermediaries. Two such plans participating in the study indicated that some IPAs or medical groups were more stringent with their referral practices and treatment decisions than plan policies would dictate. Both plans closely monitored intermediaries' performance and sometimes overruled treatment denials when members complained.

Several plans also attributed lower scores on these measures in certain counties to a shortage of specialists or ancillary care providers. In some cases, these were new markets, where provider contracting was still in its early stages. In others, they were marginal markets inherited from mergers or acquisitions, or where coverage was required through employer contracts.

Getting Needed Care
<ul style="list-style-type: none"> • Educate prospective members up front about the scope and limitations of covered benefits, referral policies, and procedures for obtaining necessary approvals • Build on established referral networks when constructing provider panels • Expedite referrals for routine preventive care or established diagnoses, especially chronic conditions • Empower staff to resolve problems in the first instance and to take patients "out of the middle" of disputes about covered benefits or services

Specific plan-level operating practices that contribute to higher CAHPS performance on these measures include:

- Educating members up-front about plan benefits, policies, and procedures. Most of the higher-performing plans that participated in the study

said much of their success on these measures occurred because their members knew what to expect before they signed on. Particularly when recruiting Medicare beneficiaries, the plans invested heavily in educating prospective members about the scope and limitations of covered benefits, referral policies, and procedures for obtaining necessary approvals. This was especially important in relatively immature markets, where members were likely to have had little prior experience with managed care, and in light of BBA-induced changes in Medicare.

Most plans acknowledged that this practice reflected a marked departure from the usual practice on the commercial side of their operations, where the job of communicating to prospective members more often fell to employers (and where employers often actively prevented plans from communicating directly with employees). Nonetheless, several plans recognized the value of managing new members' expectations, given the highly charged and rapidly changing environment of managed care. These plans actively sought to reach out directly to new and potential members—e.g., through community meetings devoted to particular issues of policy and through proactive telephone calls to new members, rather than waiting until members called them.

In this respect, plans' experiences with direct recruitment of Medicare beneficiaries was often instructive. Plans whose Medicare business relied more on "aging-in" commercial enrollees after they turned 65 reported fewer efforts at educating members prior to enrollment in the Medicare product, apparently on the assumption that they were already familiar with the way the plan worked. These plans acknowledged, however, that many members were unprepared for the changes in benefits that Medicare coverage entails and that the switch could, at times, lead to a great deal of confusion.

- **Building on established referral networks.** Because members are most likely to experience difficulties in getting needed care when they need (or want) to see a non-contracting provider, plans that contracted with providers in established referral networks tended to be in a stronger position. Staff- and group-model plans that contracted with highly integrated multispecialty group practices would seem to have a particular advantage in this regard. However, IPA- and network-model plans that built their networks around hospital-based provider systems were also among the strong performers on these measures.

Here, again, members' perceptions of plan performance may have been colored by restrictive practices of contracting medical groups. For example, in one plan whose

risk-bearing medical groups managed their own subcontracts with specialists and ancillary care providers, members were sometimes unable to get referrals to the providers of their choice, even though these providers were ostensibly participating plan providers. This, the plan acknowledged, was a common cause of complaint and confusion among members affiliated with certain medical groups.

- **Managing and/or expediting referrals for identified diagnoses.** Most of the plans participating in the study recognized that while requiring primary care physician referrals for ancillary or specialty care was critical to controlling costs, the practice sometimes created barriers and delays for patients who needed care. Plans were particularly sensitive to barriers to care related to HEDIS measures of quality—e.g., mammograms, pediatric immunizations, or ophthalmic examinations for patients with diabetes—and many waived referral requirements for these preventive care services.

In addition, several plans permitted patients diagnosed with chronic diseases unrelated to these quality measures to see participating specialists without a primary care provider's (PCP) referral—sometimes on a case-by-case basis, at the PCP's discretion, and sometimes through formal programs of expedited referral.

- **Empowering staff to resolve problems.** One of the biggest acknowledged sources of frustration for members at many of the participating study plans was the length of time it took for plans to settle disputes about claims or covered services. In some highly publicized cases, members died while decisions regarding treatment were pending. Although such cases were rare, it was not uncommon for members to be caught in the middle of disputes between plan officials and providers about matters of medical necessity. Nor was it uncommon for members to pay the price (literally and figuratively) when policies were unclear or when services did not strictly adhere to plan policies and procedures.

Two of the participating plans were taking positive action to take the patient out of the middle of such disputes and to give front-line staff the authority and explicit responsibility to solve members' problems without a lot of red tape. One practice, referred to as "pay-and-educate," gave front-line customer-service staff the authority to approve claims (up to a specified dollar amount) that would otherwise have been denied, when members using services for the first time did not follow proper procedures. Another practice entailed designating point people at the plan and at provider sites who could, on their own authority, take whatever action was

necessary to resolve disputes quickly, when members were deemed either to be at high clinical risk or likely to disenroll.

Doctors Who Communicate Well

CAHPS questions related to this area assess members' perceptions of their direct interactions with health care providers in the plan, rather than their perceptions of the plan itself (Appendix 1). As with the measures of access described above, plans that track provider performance on these measures report wide variation from one practice to another, and this observation is sometimes reflected in within-plan variations in CAHPS performance.

Noteworthy plan-level practices designed to improve physicians' or medical groups' performance on these measures include:

Doctors Who Communicate Well

- Recruit doctors known for their ability to communicate well with patients
- Give physicians feedback on their performance, and offer training to improve communication
- Encourage the use of scheduling protocols that eliminate inflexible appointment slots
- Use clinical practice guidelines that incorporate shared decision-making cues and protocols

- Get the “best” doctors on the panel. Several of the higher-performing network-model plans that participated in the study attributed their performance on the doctors-who-communicate-well measures to their deliberate searches for providers with the best reputations in the community. Two plans affiliated with faith-based systems emphasized the importance of religious mission to the physician practice culture. Group- and staff-model plans, whose physicians were more interested in patient care than in academic careers or making a lot of money, also emphasized the importance of collaborative practice culture in attracting physicians. However, some group- and staff-model plans also acknowledged problems with provider morale at some clinics, the result of staff reductions and/or increased workloads.
- Track physicians' performance, with feedback and training. Medicare CAHPS data does not include information about the performance of individual providers at specific clinical sites, but all of the group- and staff-model plans in the study routinely used their own survey tools to monitor the performance of individual physicians, drawing on patient feedback about recent encounters. Several of the network-model plans likewise monitored the performance of those physicians whose patient panels included a large enough number of plan members

to yield a meaningful sample (the usual rule of thumb was a minimum of 100 plan members per panel).

All plans that monitored performance also offered training to physicians found to be deficient in communication skills. Several tied performance on these measures (as well as other measures of clinical quality performance) to financial incentives. One plan explicitly refused to pay physicians extra for performance that, in the plan's view, ought to have been a routine part of practice. However, the plan did offer training, and it required contracting medical groups that had been found deficient to develop corrective action plans.

Network-model plans that operated in highly competitive environments, where providers contracted with many different health plans, were less likely to monitor physician performance because of the small number of plan members on any given physician's panel. For similar reasons, few plans were able to monitor the performance of contracting specialists.

- Use scheduling protocols to eliminate inflexible time slots. Because it recognized the link between tight scheduling practices and patients' interactions with their physicians, one group-model plan encouraged clinical sites to abandon scheduling protocols that called for shorter or longer time slots for different types of appointments in favor of standard time slots based on an average. While the primary intention was to free up time in the schedule so that patients could be seen more quickly, the practice also removed some of the pressure to rush through the shorter appointments in order not to get behind.
- Use clinical practice guidelines that incorporate decision-support technology and shared decision-making. Although all of the plans under study were involved to some degree in the development of disease-management programs, several of the IPA- and network-model plans reported physician resistance to programs that incorporated practice guidelines or that brought the plan into direct contact with patients on matters relating to clinical management. On the other hand, the staff- and group-model plans in the study were actively developing guidelines that often included cues or aids for communicating with patients and involving them more actively in continuing disease management. One staff-model plan in particular was committed to the development and deployment of decision-support technology and evidence-based clinical guidelines that incorporated shared decision-making materials and protocols. Another group-

model plan actively taught physicians about the value of involving patients in decision-making and taught communication techniques that would foster such involvement.

Courteous and Helpful Office Staff

CAHPS questions relating to this area assess members' perceptions of their interactions with staff at clinical sites, rather than their perceptions of the plan's customer service. Here again, plans that track provider performance on these measures report wide variation from one

practice site to another. Noteworthy plan-level practices aimed at improving clinical office staff performance on these measures include:

Courteous and Helpful Office Staff

- Provide feedback on patient satisfaction by clinical site
- Offer plan-sponsored training in service quality to physicians' office staff

- Track performance by practice site, with feedback and training. The CAHPS survey does not provide information about the performance of specific clinical sites on these measures, but several of the participating plans routinely queried patients about their interactions with clinical office staff as well as about other aspects of clinical office visits. This allowed plans to identify benchmark performers, as well as those needing improvement, and to organize formal and informal information-sharing activities.
- Offer plan-sponsored training in service quality to physicians' office staff. In addition to information-sharing activities, several plans offered specific training in service quality to clinical office staff. One high-performing plan offered training designed to heighten awareness about the needs of seniors.
- Provide plan customer-service support at clinical sites. The CAHPS survey asks plan members to distinguish between plan customer service and courtesy of physicians' office staff. However several respondents observed that members' questions about plan coverage, policies, and procedures often arise at the point of service, and that members do not always distinguish between plan-level and office-level customer-service functions. This is particularly the case at staff- and group-model plans, where patients are accustomed to receiving care at multiservice clinics. Therefore, several plans placed plan customer-service representatives at the higher-volume clinical sites.

The wider dispersal of providers in network- and IPA-model plans precluded on-site customer service, but several of the plans under study sought to support physicians' office staff in other ways—e.g., by providing direct telephone access to plan member-services staff, computer links to member-services information, training for office staff on plan policies and procedures, and user-friendly informational materials.

Plan-Level Customer Service

These questions ask members about the helpfulness of information they get from plan customer-service representatives (Appendix 1). One of the most striking findings of the field investigations was the extent to which all of the plans participating in the study had invested or were investing heavily in customer service, especially for Medicare members. In some of the higher-performing plans, this represented a long-term commitment. In lower-scoring plans, the investment was

often more recent—a deliberate response to identified problems, sometimes the result of sudden changes in enrollments or benefits. Some noteworthy practices in this area:

Plan-Level Customer Service
<ul style="list-style-type: none">• Coordinate marketing with customer service functions• Train product-specific customer service teams, especially for Medicare products• Support customer service functions with integrated information systems• Enhance direct outreach to members through public meetings, report cards, and other communications mechanisms

- **Coordinate marketing with customer service.** One of the distinguishing characteristics of the participating plans that had higher levels of performance on the Medicare CAHPS survey was their personalized approach to marketing their Medicare product. As mentioned above, this entailed educating prospective and new members about plan services. It also often entailed establishing a strong one-on-one relationship between sales representatives and prospective members, who were encouraged to call with any questions or concerns. In some plans, sales representatives continued to make themselves available to new members (through direct telephone lines or pagers) in the period immediately following enrollment. In others, customer-service representatives attended recruitment meetings to answer specific questions about benefits and coverage. Practices such as these assured that prospective and new members received consistent information.
- **Train product-specific customer-service teams.** All of the plans under study had established call centers designed to respond quickly to calls from plan members, and all of them monitored the performance of such centers using

standard metrics such as average-speed-to-answer and call-abandonment rate. What distinguished one from another, however, was the recruitment and training of the customer-service representatives who answered the calls and their degree of specialization in Medicare-related policies and practices.

Several plans told the study team that they recruited older, more experienced workers for these positions, looking specifically for work experience in health care or customer service. They also trained new hires extensively—not only on plan policies and procedures, but also in communication and related customer-service skills. Most of the higher-performing plans also observed that serving the needs of Medicare enrollees requires more extensive training and experience, both because of the complexities of Medicare policy (including changes brought about by the BBA) and because of the special needs of the elderly population. In some cases, plans identified more experienced customer-service representatives who served as backup experts in Medicare.

A more effective practice, however, was to directly route all incoming calls from Medicare enrollees to dedicated and specially trained customer-service representatives. Some larger plans maintained separate 1-800-telephone lines for Medicare beneficiaries, so that elderly callers would not have to negotiate telephone triaging systems. A smaller plan cross-trained staff in customer service and claims processing, and organized them into separate teams for Medicare, Medicaid, and larger commercial accounts. Each staff member spent half of each working day taking incoming customer service calls and half on claims. This gave them ready access to information on the status of individual claims and reportedly helped prevent the burnout common to call-center staff.

- **Develop integrated information-support systems.** Customer-service representatives' ability to respond to members' inquiries depended not only on the quality of their understanding of relevant plan policies, benefits, and procedures, but also on their access to information. Information on the status of claims, complaints, or grievances was especially critical, although staff outside the customer-service area typically handled these functions.

Well-developed information support-systems in several of the plans visited made it possible for customer-service representatives to track the status of any caller's claim or concern without the need for a transfer or lengthy follow-up. While larger plans often had the advantage of superior technological capabilities, it was not so much technology that distinguished performance but an emphasis on information-sharing

and access, and an appreciation of the importance of customer service. One high-performing plan in the study still relied heavily on paper, as well as on several separate and non-communicating tracking and information systems it had inherited from recent mergers. At the time of the visit, it was still a long way from achieving any sort of integrated data infrastructure that could support internal operations. Nonetheless, the customer-service representatives had ready access to the information they needed to respond to members' queries, or they knew how to get it quickly.

- **Enhance direct outreach to members.** Most plans, including those that participated in this study, have limited direct contact with members except during enrollment periods or in response to member-initiated inquiries. Some of the plans in the study deliberately sought to maintain this distance, to keep the plan as "invisible" as possible to the members, recognizing that members' primary relationships were with their providers. However, several plans were departing radically from this usual and customary practice, looking for ways to reach out directly to members, to elicit their concerns, to inform them about changes in policies and practices that would affect them, and to involve them in decisions. One plan held regular "town meetings" chaired by senior plan officials, and open to the public at various locations throughout its market area. It also issued regular "report cards" to members (as well as to employers) about the performance of contracting medical groups on key measures of quality, including patients' reported experiences with each group.

III. DISCUSSION: HOW VARIATIONS IN ENVIRONMENT, STRUCTURE, AND STRATEGY RELATE TO CAHPS PERFORMANCE

A variety of characteristics related to a plan's environment, history, mission, ownership, structure, and governance can affect its performance on the CAHPS survey, either because the characteristics shape the plan's strategy and operations or because they independently shape members' perceptions and experiences. The focus of this study was on discretionary plan-level operating practices that contributed to positive consumer experiences.

However, in order to gain a better understanding of the relationship of broader environmental and strategic issues that affect plan operations, the study team also sought information about these issues before each visit. These observations are summarized briefly below.

Environmental Factors

The managed care markets in which the plans that participated in the study operated varied enormously. As suggested above, the environment of local markets turned out to be

even more important to an understanding of the differences in plan practices and performance than the study team had anticipated. Moreover, statistics on managed care market penetration revealed little about the “maturity” of any given market. Instead, a number of factors contributed to the managed care environments of the sites visited, shaping plan operations and performance as well as providers’ and consumers’ expectations and behavior. These included the degree of integration of the principal health care delivery systems in the market area, the history of third-party constraints on health care costs, the professional culture of practicing physicians, the history of managed care in the area, and managed care’s penetration.

The effect of the state regulatory environment on plan operations also varied from state to state. Although the highly charged and highly visible atmosphere surrounding managed care as a public policy issue was evident in most of the states visited, the clout and/or regulatory teeth of the relevant monitoring or oversight agencies varied. Respondents especially remarked on the importance of state-level oversight in Massachusetts (the Attorney General’s office), in California (the Department of Corporations), and in Oregon.

With these characteristics in mind, the key factors that shape the markets visited are suggested in the matrix shown in Table 2, and in the discussion, below.

Table 2. Key Characteristics of Selected Markets

Market	Integration of Delivery Systems	Constraints on Health Care Costs	Quality as Part of Practice Culture	History of Managed Care	Managed Care Penetration	State Legislative/Regulatory Oversight
MA	moderate	strong	moderate	moderate	strong	strong
FL	weak	weak	weak	moderate	strong	weak
AL	weak	weak	weak	weak	weak	weak
So. CA	strong/moderate	strong	strong/moderate	strong	strong	strong
WA	strong/moderate	strong	strong/moderate	strong	strong	moderate
OR	strong/moderate	strong	moderate	strong	strong	strong

- The Massachusetts market is a moderately mature managed care market, relative to those included in this study. It supports some moderately integrated delivery systems in the form of multispecialty group practices (many of them academically based), and has an especially strong history of cost constraints influenced by large employer-purchaser coalitions. Massachusetts has a 25-year history with managed care, and several plans have national visibility as academic, industry, and policy leaders. The state also has an active HMO group, which is influential in state

policy discussions. The academic and managed care influence in the state has also generated interest in evidence-based clinical practice in some key parts of the professional community. Managed care penetration is also fairly high, with many large employers offering nothing but managed care options to employees.

- Although Miami, Florida, is often considered a “mature” market because of its high degree of managed care penetration, it is a markedly immature market in most key respects. Health care delivery systems are only loosely (and relatively recently) integrated into hospital-based PHOs and IPAs, with most physicians practicing in solo or small group fee-for-service environments. There is virtually no history of employer-influenced cost constraints, giving Miami the highest overall cost structure of any of the markets included in this study. Although Miami has a fairly long history with managed care (similar to that of Massachusetts), physicians are accustomed to practicing with very little oversight of costs, quality, or patterns of utilization.
- Birmingham, Alabama, is the least mature managed care market of those included in this study. Here, too, delivery systems are loosely integrated into recently created IPAs, although the practices affiliated with the University of Alabama at Birmingham medical school and the extensive Baptist hospital system may provide some degree of integration among specialties and levels of care. Physicians continue to practice in a mostly fee-for-service environment, with few cost constraints and little oversight of practice patterns. Managed care in the state has only been around for about 10 years, and statewide penetration remains low—traditional Blue Cross/Blue Shield plans dominate this market.
- The Kaiser presence in the Southern California market makes for a long history with managed care based on highly integrated delivery systems and a population-management perspective. As in Massachusetts, large purchasers have played a powerful and visible role in setting policy and constraining costs. However, the solo fee-for-service sector, dominated by traditional Blue Cross and commercial indemnity plans, is also strong in the region, creating a very mixed environment.
- In the Puget Sound region of Western Washington, the influence of large employers from the aircraft and lumber industries and the 50-year history of the Group Health Cooperative of Puget Sound have created a market with a strong history of cost constraints, integrated delivery systems, and a practice culture

attuned to the principals of population-based medicine. However, solo fee-for-service practice dominates in Eastern Washington.

- Oregon, like Southern California, has a long history of managed care based on integrated delivery systems, notably with Kaiser and Physicians' Association of Clackamas County (PACC). Here too, large, quality-conscious employers in the high-tech industry have exerted a strong influence on policy and cost constraints. In the Portland and Eugene markets, especially, managed care penetration is high and the practice culture of the dominant physician groups is attuned to managed care, if less to population management.

Mission, Culture, and Leadership: Each of the plans participating in the study exhibited distinct historical patterns of development that shaped their leadership, strategic mission, and organizational cultures. Four had their roots in clinical provider systems (two of which were faith-based); four were designed explicitly to provide and/or manage the health care of defined populations; and one was primarily an insurance venture. The historical roots and mission of each organization clearly contributed to its strategic approach to managing care, specific operating practices, and the overall organizational "climate" of each plan. Contrary to the study team's expectations, these observed differences did not necessarily translate into differences in performance on the CAHPS survey.

Ownership, Structure, and Governance

The principal differences in ownership, structure, and governance among participating plans were related primarily to profit status; the geographic scope of the corporate purview; the integration of insurance and delivery functions in plan structure, governance, and operations; and consumer or community involvement in governance.

Given the complexities of corporate structure, profit status alone told little about a plan's operations: one plan, for example, was a for-profit subsidiary of a nonprofit provider system; another was a nonprofit subsidiary of a for-profit insurance company; and still another nonprofit plan purchased its services from a national for-profit plan.

The geographic scope of operations was more problematic. Only two of the participating plans were national in scope. The others confined their operations to a single state, although they were sometimes affiliated with larger regional, national, and even international corporate entities. The literature suggests that the larger plans may have an advantage in terms of access to capital and economies of scale in major capital investments (e.g., information systems). However, CAHPS performance is clearly the result of *very*

local conditions. Scores vary widely from one Medicare contract to another, even within a given state or region. In this study, the smaller, more local plans, which were closer to the communities they served, appeared to have the advantage. Moreover, the multiplicity of contracts carried by the larger plans and the wide variation in their CAHPS performance made it difficult to assess their overall performance.

Providers played an active role in the governance of several participating plans, although formal involvement in governance was no guarantee of strong influence over policy. In others, plans maintained an arm's-length relationship with the providers with whom they contracted. While providers' involvement in plan governance and policy-making clearly affected operations, it did not appear to relate to performance on CAHPS measures.

Consumer involvement in governance and policy-making was less in evidence. Only one plan had formal consumer representation on its governing bodies, although others made use of community advisory boards for intelligence about the community and for public relations purposes. However, consumer involvement did not appear to affect operations in any substantive way, in most cases, nor did it relate to CAHPS measures of performance.

Identified Customer Base and Target Market

Plans exhibited two different strategies in their Medicare businesses. One entailed "carving out" the Medicare side of the business, and designing totally distinct products, marketing strategies, and customer services. The other entailed "aging in" commercial enrollees as they turned 65, retired, or became eligible for Medicare. In general, the "carve-out" strategy, which usually involved intense one-on-one marketing, was related to higher CAHPS performance. Because the traditional customers of health plans are brokers or purchasers, rather than patients or individual consumers, most plans knew relatively little about the end users on the commercial side of the business. Perhaps for this reason, "aging in," practiced more often in markets with larger employers, was not related to higher CAHPS performance, in spite of the longer-term relationship between plan and members that was often in evidence.

Differences in Plan Type and Contractual Relations with Providers

Plans participating in the study included traditional staff-model plans that directly employed salaried physicians; group-model plans that contracted with both exclusive and nonexclusive medical groups; IPA- and PHO-model plans, in which the plans contracted with intermediaries; and network-model plans, in which the plans contracted with individual physicians or small medical groups. Most had mixed arrangements, with staff-

and group-model plans relying on networks in new market areas and for some specialty referrals.

Among participating plans that had both staff- or group-model arrangements plus networks, CAHPS scores tended to be higher in network markets. However, observed differences in CAHPS performance appeared to have more to do with the setting of clinical practice (clinic versus private physician's office) and with characteristics of the provider panel than with plan type. CAHPS survey respondents reported fewer problems getting appointments in the network-model plans participating in the study than in staff- or group-model plans. However, staff- and group-model plans were more likely to be actively addressing identified problems with access through continuous monitoring, innovations in scheduling protocols, and physician incentives.

Respondents also reported fewer problems with long waits in the waiting room in group- and staff-model plans (that is, in clinic settings) than in network plans with solo office practices, suggesting that practices in clinic settings were better at keeping to established schedules. CAHPS respondents reported lower levels of satisfaction in these settings on questions relating to doctors spending enough time with patients, listening to patients, and giving understandable explanations—suggesting that tighter schedules in staff- and group-model plans may be constraining patient-physician interactions. However, one staff-model plan participating in the study was notable in its high scores across both sets of measures.

Physician payment mechanisms among the participating plans included salary plus incentive, capitation for primary care, capitation plus incentive, and discounted fee-for-service. How physicians were paid varied with market characteristics (with some form of discounted fee-for-service prevailing in the less-mature markets), but did not appear to be related to CAHPS scores at participating plans.

Physicians were paid incentives only in those plans capable of profiling physician practices—that is, those that had both integrated information-systems capabilities and provider panels with sufficiently large enrollments of plan members. Incentives were most often paid for quality of care (e.g., HEDIS quality measures) and for patient satisfaction, although utilization and referral patterns were also monitored. Although the amounts of incentives paid were not large, physicians reported paying attention to them, especially when they had a part in designing the incentive system. However, CAHPS performance varied among plans that offer incentives to physicians, suggesting that other factors affected consumers' perceptions of physicians.

Differences in Risk-Bearing Arrangements

Risk-bearing arrangements at participating plans varied widely, depending on markets. The two higher-performing plans in less-mature markets held IPAs or PHOs at risk, but not individual physicians (who were paid discounted fee-for-service). However, both were in a state of transition. The lower-performing plan in one of these markets held individual physicians in the network at full risk for primary care.

Degree of Physician Autonomy in Care Management

In immature markets, physicians were accustomed to a great deal of autonomy in practice decisions and very little oversight of practice patterns or utilization. The two higher-performing plans in these markets had done little to constrain physician autonomy, relying on other methods to control costs. However, neither plan believed that such a low-key approach to care management was financially sustainable, especially in light of reduced reimbursement levels under the BBA. At the time of the site visit, one was poised to transfer financial risk as well as care management functions to newly organized IPAs. The other expected a major strategic restructuring, in light of participating physicians' resistance to continued fee reductions and the affiliated PHOs' apparent inability (or unwillingness) to control costs. The one lower-performing plan monitored practice patterns more closely, both in selecting physicians for its panel and in monitoring performance.

Plans in more mature markets tended to be more active in monitoring practice patterns for both quality and utilization measures. Staff- and group-model plans relied more on practice culture and feedback to influence physician behavior than on utilization management or approval mechanisms. Although reported levels of physician satisfaction varied with these differences in practice, variations in CAHPS scores did not appear to be related to these differences in practice at the plans visited.

Case Management and Care Management

Participating plans varied in the extent to which they were directly involved in both case management (management of high-cost cases) and care management (prevention and long-term management of chronic illness). Case management tended to be dictated by the need to control high costs over the short term, especially as related to the severely disabled (spinal cord injuries, high-risk infants). Case management therefore affected a relatively small population. Care management appeared to be driven by a longer-term commitment to population medicine in some plans and by HEDIS and NCQA requirements in those with shorter-term horizons. In either case, care management potentially affected a larger population. Care management priorities were driven, accordingly, by internal measures of population need (for example, most common diagnoses associated with mortality and

morbidity or high total costs), or by HEDIS requirements. Other differences noted included the use of homegrown versus purchased clinical guidelines, and an emphasis on professional consensus versus evidence-based guidelines.

The study team observed two general strategies of care management among participating plans. One entailed direct outreach to the membership—e.g., reminders about mammograms, eye exams for diabetes, childhood immunizations, and general member education. The other entailed physician support—e.g., profiles of the patient population, reports on the status of preventive care.

Contrary to the study team’s expectations, a commitment to population management was not necessarily associated with higher CAHPS scores. Some respondents commented that patients do not define themselves in the epidemiological terms that population managers use, and that they often resist outreach efforts. Other respondents noted that patients are more receptive to messages that come from physicians than to those that come from the plan. One high-scoring plan’s strategy was to reach out directly to members (while also supporting physicians), but to do so as representatives of the physicians (with the physicians’ permission).

IV. STRATEGIES SUPPORTING PATIENT-CENTERED PERFORMANCE

Understanding effective practices requires distinguishing among factors that contribute to plan performance on the CAHPS survey; plan practices that contribute to members’ perceptions of performance now; and practices likely to improve organizational performance, vis à vis patients’ perceptions, over the long term.

Focusing on this last category, the study team identified several crosscutting strategies essential to developing and sustaining patient-centered practices in managed care over the long term.

Identifying Plan Members as Primary Plan Customers

One of the critical factors to the performance of any organization is the extent to which it identifies and understands the needs of key customers

and market segments, including the end users of its products and services. Because health plans have traditionally identified purchasers (employers, brokers) rather than individual

Strategies Supporting Patient-Centered Performance

- Identifying plan members as primary plan customers
- Managing consumers’ expectations
- Recognizing consumers’ perceptions of plan and provider responsibilities
- Incorporating members’ perceptions in quality measures

consumers as their customers, they often know relatively little about the end users in their markets—i.e., plan members or health care consumers. This is particularly true on the commercial side of the business, except in those rare instances where large employers or unions permit direct access to consumers.

One of the most compelling insights to be gleaned from the higher-performing plans was their discovery that competing successfully for Medicare business required a markedly different approach—one based on an understanding of market demographics, the specific needs of the elderly, and a one-to-one approach to marketing to individual Medicare beneficiaries. This is in sharp contrast to the approach usually taken on the commercial side of the business, and no such strategy was deemed necessary in instances where members of commercial, employer-based plans could be “aged in” to the Medicare product as they reached retirement age (often as part of an employer- or union-sponsored retirement benefits package). Only one of the plans in the study relied primarily on “aging in” as a strategy for building its Medicare business. Respondents there acknowledged, however, that Medicare benefits were different enough to cause confusion among the aged-in members. Plans with significant Medicaid populations also acknowledged the special characteristics and needs of this population.

Several plans participating in the study specialized, to varying degrees, in Medicare and considered their Medicare product to be their flagship offering. These often included practices and services tailored to the needs of the elderly—including social support programs and training for physicians and their office staffs on developmental needs related to aging. One of the best examples of this sort of explicit market segmentation was in one Miami plan, which recognized that the needs and expectations of the elderly Cuban population (who were accustomed to all-inclusive clinic-based care provided by the state) and retirees immigrating from the Northeast (accustomed to mostly solo, fee-for-service physician office practices) were very different. The plan showcased one particular group practice with which it was affiliated that offered highly integrated clinical and social services to elderly Cubans.

Some plans were beginning to apply the lessons learned from Medicare to the commercial side of the business as well, by finding ways to reach out to members directly. One plan, in particular, described itself as shifting from a “provider-focused” to a “member-focused” orientation.

Interestingly, however, plans committed to population medicine—e.g., those with relatively stable membership over time, especially with large employer contracts—tended to define and understand markets in terms of their clinical epidemiology, rather than in

social or demographic terms. This did not necessarily translate into an understanding of members' subjective needs. Several plans acknowledged that members did not think of themselves in clinical terms, which complicated plans' clinical outreach efforts, and that understanding patients' subjective needs would likely make such efforts more effective.

Managing Consumers' Expectations

High-performing plans invested heavily in informing members about plan operations, benefits, and services prior to and immediately after enrollment. This was particularly the case for targeted Medicare beneficiaries, who were identified as especially savvy consumers. In several plans, sales representatives met with interested parties in their homes (HCFA requires that they be invited before making such visits, and prohibits soliciting new members door-to-door). In one case, sales reps carried beepers and invited would-be members to call at any time with questions. In other plans, member-services representatives called all new enrollees to review benefits and procedures and to answer questions. Although the practice was more common for Medicare beneficiaries, several plans extended the practice to commercial members. Medicare beneficiaries who "aged in" from commercial plans were often assumed to understand how the plan worked. Because of the differences in Medicare coverage, however, plans acknowledged that the switch often created confusion.

Recognizing and Managing Consumers' Perceptions of Plan and Provider Responsibilities

Plan members may have little practical understanding of the divisions of responsibility for decision-making, assumption of risk, or other matters related to managed care operations, although they likely have prior assumptions about where the locus of responsibility ought to lie for administrative and clinical functions. Several of the plans participating in the study were sensitive to members' perceptions in this regard and to the potential for confusion and misunderstanding. However, this sensitivity yielded two different strategies for managing consumers' perceptions.

The more common strategy might be described as an effort to keep the plan's involvement in clinical decisions or practice as invisible to members as possible—recognizing that members look to caregivers, not to health plans, on clinical matters. In some cases, a plan's involvement in clinical practice was invisible because it was virtually nonexistent. Several plans—especially those operating in relatively immature markets with historically few cost constraints (and historically high AAPCCs)—took a deliberately low-key approach to utilization management, or delegated such functions entirely to providers or their risk-bearing entities (IPAs or PHOs). It was not clear, however, that invisibility

bought at this price was sustainable over the longer term, since such strategies often failed to control costs.

More mature plans operating in more mature markets tended to be more active in various aspects of clinical care management—including utilization review, case management of high-risk or high-cost cases, chronic-disease management, and preventive care. Depending on the sophistication of their information systems, most plans could identify patients at risk using plan-level claims (or encounter) data. They could then use this data to meet HEDIS reporting requirements, monitor providers' quality performance, or target members who were overdue for preventive services. While a number of plans used this information to reach out directly to members, others deliberately sought to maintain a low profile by focusing instead on supporting physicians in their care-management functions. One noteworthy practice effectively combined both practices. The plan's care-management team routinely contacted members directly, through reminder letters and telephone calls, but did so *explicitly on behalf of their physicians*. What was unusual about this practice was not the calls and letters themselves, but rather that they were made under the physician's auspices.

A far less common, but emerging strategy—especially among plans seeking to redefine themselves as member-centered—entailed reaching out directly to members in an effort to engage them in critical decisions about their care or continuing management. Instead of maintaining a low profile on clinical matters, these plans sought to enhance their visibility among members as active promoters of clinical quality. One plan in particular not only monitored the performance of participating providers on critical quality measures, but also gave this information directly to consumers. Several plans, through their disease-management programs, also educated members about clinical guidelines and treatment options and prompted them to question their providers during office visits. It is worth noting, however, that the plan most committed to this strategy operated in a very mature market, with a long history of highly integrated delivery systems operating in a managed care context. On the other hand, one plan that was attempting to establish a similar public presence in a market characterized by a high degree of physician autonomy appeared to have less success.

Incorporating Members' Perceptions in Quality Measures and Improvement Strategies

All of the plans in the study were involved to some degree in the measurement of quality performance and member satisfaction (often to satisfy external reporting requirements related to HEDIS), and none of them relied solely on the CAHPS survey for information on member satisfaction. What distinguished the performance of one plan from another,

however, was the extent to which high-performing plans routinely used statistical measures of performance for internal quality-improvement purposes, and the extent to which they integrated data on members' experiences into these performance measures.

In this regard, the differences among participating plans were vast. At the low end of the spectrum, data-gathering activities were driven only by the requirements imposed by oversight or accrediting organizations. At the high end, the most effective practices entailed routinely gathering information on past, present, and potential members' perceptions and experiences at a variety of levels and from a variety of sources. These included community surveys of members' and nonmembers' perceptions of the plan; plan-wide surveys of member satisfaction; surveys of patients' experiences and satisfaction at a given contracting medical group or clinical site; surveys of patients' subjective experiences and satisfaction with encounters with individual physicians or physicians' offices; and routine and systematic collection and analysis of information regarding customer-service queries, complaints, and grievances.

Better-performing plans also had well-established procedures for feeding this information, along with information on other aspects of clinical quality, to plan-wide strategic planning and quality improvement committees, which used it to identify priorities and to establish continuing performance measures. The plans also used the information to give routine feedback about performance to contracting physicians or medical groups.

Linking Providers' Incentives to Patients' Reported Experiences

Monitoring and improving the quality of member-centered performance requires the ability to track the performance of key components of the system. In practice, a plan's ability to profile the performance of individual providers or medical groups—key components of a health plan—is limited by the numbers of plan members on any given provider's or group's panel. For this reason, the group- and staff-model plans in the study, most of whose providers served plan members exclusively, were more likely to provide detailed reporting on provider performance. However, several network- or IPA-model plans also tracked provider performance to whatever extent was feasible.

Performance measures commonly used included measures of financial performance (such as productivity, resource use, patterns of referral), clinical quality (most often HEDIS measures), and patient satisfaction (overall satisfaction as well as feedback about specific provider encounters). Plans used this information both to assess providers' performance for contracting purposes and to create incentives for improvement in these areas.

Among the plans that routinely tracked physicians' performance on quality measures (including patient satisfaction and service quality), however, the use of financial incentives to improve performance elicited a mixed response. Where financial rewards for performance were offered, they did not represent a significant portion of physicians' revenues. However, several physicians commented that the dollar amount was large enough to get their attention, and it sent the message that the plan cared as much about quality as it did about costs. On the other hand, one plan that assiduously tracked and reported on quality performance and patients' experiences with care was philosophically opposed to rewarding physicians financially for what in their view ought to have been a routine part of practice. However, the plan did give medical groups feedback about their physicians' performance, provided training and education on the "art of caring" as well as the clinical aspects of care management, and required corrective plans of action as part of its contract negotiations.

Thus, incentives for improvement could be financial or nonfinancial. The critical factors here appear to be tracking the performance of providers and feeding the information back to them, and including patients' reported experiences in routine measures of quality.

CONCLUSION

While observations based on a field study of nine health plans cannot be generalized across the universe of managed care, the methodology pursued for this study has made it possible to probe a complex array of issues in an arena where there is little uniformity or consistency in forms, structures, and functions, and where little is known about the relationship between structures, practices, and outcomes. Our findings suggest that researchers and policy analysts should be cautious in interpreting aggregate performance measures based on disparate plans and markets, or in using such data to identify benchmark performance.

Notwithstanding these idiosyncrasies in performance, we identified discretionary practices at the plan level that contribute to members' positive experiences with managed care plans and providers. We also found that plans poised to sustain patient-centered performance share a strategic focus on the individual plan member as the primary plan customer; a recognition that members' subjective experiences are integral to the quality of care; a commitment to quality assessment and improvement that incorporates measures of members' perceptions and experiences; and a relationship with providers that reinforces a commitment to this conception of quality.

APPENDIX 1. CAHPS MEASURES AND DIMENSIONS

Getting Care Quickly

Q 17—(Of those who phoned doctor’s office or clinic during a weekday)—“In the last six months, how often did you get the medical help or advice you needed when you phoned the doctor’s office or clinic during the day, Monday to Friday?”

Q 20—(Of those who tried to see a doctor or health professional right away)—“In the last six months, when you tried to be seen for an illness or injury, how often did you see a doctor or other health professional as soon as you wanted?”

Q 22—(Of those who tried to make an appointment for regular or routine health care)—“In the last six months, when you needed regular or routine health care, how often did you get an appointment as soon as you wanted?”

Q 26—(Of those who went to an office or clinic)—“In the last six months, how often did you wait in the doctor’s office or clinic more than 30 minutes past your appointment time to see the person you went to see?”

Getting Needed Care

Q 5—“With the choices your health plan gives you, was it easy to find a personal doctor or nurse you are happy with?”

Q 12—(Of those who thought they needed a specialist)—“In the last six months, how often did you see a specialist when you thought you needed one?”

Q 14—(Of those who needed a referral)—“In the last six months, was it always easy to get a referral when you needed one?”

Q 37—(Of those who went to doctor’s office and thought they needed tests or treatment)—“In the last six months, how often did you get the tests or treatment you thought you needed from your health plan?”

Q 50—(Of those whose health plan was asked to approve or pay for care)—“In the last six months, how often did your health plan deal with approvals or payments without taking a lot of your time and energy?”

Doctors Who Communicate Well

Q 29—(Of those who went to office or clinic)—“In the last six months, how often did doctors or other health professionals listen carefully to you?”

Q 30—(Of those who went to office or clinic)—“In the last six months, how often did doctors or other health professionals explain things in a way you could understand?”

Q 31—(Of those who went to office or clinic)—“In the last six months, how often did doctors or other health professionals show respect for what you had to say?”

Q 32—(Of those who went to office or clinic)—“In the last six months, how often did doctors or other health professionals spend enough time with you?”

Courteous and Helpful Office Staff

Q 27—(Of those who went to office or clinic)—“In the last six months, how often did office staff at a doctor’s office or clinic treat you with courtesy and respect?”

Q 28—(Of those who went to office or clinic)—“In the last six months, how often were office staff at a doctor’s office or clinic as helpful as you thought they should be?”

Plan-Level Customer Service

Q 53—(Of those who did call plan’s customer service for information or help)—“In the last six months, how often did you get all the information or other help you needed when you called your health plan’s customer service?”

Q 54—(Of those who did call plan’s customer service for information or help)—“In the last six months, how often were the people at your health plan’s customer service as helpful as you thought they should be?”

Overall Rating of Personal Doctors

Overall Rating of Specialists

Overall Rating of Health Care

Overall Rating of Health Plan

APPENDIX 2. PROTOCOLS FOR FIELD VISITS TO MEDICARE MANAGED CARE PLANS

General Guidelines

Purpose and focus of visits: The purpose of the field visits is to gain insight into the policies and practices that affect patients' subjective assessments of plan performance, as reflected on the CAHPS survey. The primary focus of each visit will be on plan-level practices and characteristics. However, we understand that plan-level practices may be affected by market, regulatory, and other environmental forces, and that patients' subjective assessments of plan performance are likely to be mediated by their relations with individual providers.

Product: The product of each field visit will be a case report that can be used on its own or as part of larger analytical piece written for an audience of health planners, policymakers, researchers, and plan administrators.

Background work: One member of the research team will be assigned to prepare background information about the relevant plan at each site to be visited. This information will include research about plan characteristics, its environment, and any other factors that contribute to its performance on the CAHPS survey. The results of the background investigation will be refined with further questions during the site visit. This information will be written into a briefing memo for the team, which will, in turn, provide a point of departure for the written case report. Team members will meet ahead of time to discuss the issues pertinent to the plan's performance and plan a strategy for the visit.

Setting up the visit: A designated member of the team will work with a contact person at the site to identify appropriate people to interview and schedule meetings. However, the research team will take care not to abdicate control over the visit and make sure that the contact person and senior administrators understand the purpose of the visit and the protocols to be observed.

The team will arrange to interview a range of individuals at each site, including, as appropriate, the following:

- senior plan officials and policymakers
- key participating Medicare providers

- community members of governing boards
- medical directors, and
- directors and/or managers in charge of:
 - Medicare contracting
 - marketing
 - billing and finance
 - community initiatives
 - relations with large employers or other major purchasing groups
 - provider contracting
 - member services or customer relations, and
 - other identified programs

Appointments will be scheduled so that the visitors meet with *no more than one or two people at a time* (except for group meetings with managers at the beginning or end) and *without supervisors or superiors present*.

Guidelines for interviews: Team members will assume the stance of astute, but sympathetic, listeners and observers and will avoid making statements of judgment or offering advice or criticism. All interviews will be considered strictly confidential, and those interviewed will be assured that they will not be cited or quoted in print without their express permission. Interviewers will take written notes, using tape recorders only with interviewees' permission.

Topic Outline for Field Visits and Case Reports

I. General Background

A. Regulatory Environment

What is the plan's history with Medicare?

- How long has it participated?
- What is its AAPCC?

How does the state statutory, regulatory, and legal environment affect the plan's operations?

- Are there laws or regulations that restrict provider networks, regulate benefit packages, restrict benefit differentials, or otherwise affect managed care operations?
- Is there other legislation (such as "anti-takeover" legislation) that affects the plan's business operations?
- Are there recent legal decisions or experiences with litigation that affect plan operations?

B. Other Environmental Factors

What are the salient geographic characteristics of the local market?

- How is the Medicare population distributed?
- Do travel distances or transportation needs affect access to health care?

What are the salient characteristics of the provider population?

- How many hospitals and doctors are in the market area?
- How many primary care providers? Specialists?
- Are providers located in proximity to the Medicare population?
- Are there significant cultural differences between providers and the populations they serve (e.g., disproportionate numbers of foreign medical graduates)?

What are the demographic characteristics of the market?

- What percentage of the population is over 65?
- What is the average per capita income? Income distribution?

- How diverse is the population culturally, linguistically?
- Are there significant epidemiological features (e.g., incidence of chronic lung disease; occupational injuries)?

What other characteristics of the health care market affect plan operations?

- Are there major competing plans in the area?
- Do large employers or other third-party payers generally play a significant role in the managed care market?
- Are there system-wide issues affecting health care utilization patterns?

II. Overview of Plan Characteristics

A. Overall Structure and Governance

What is the plan's scope of operations?

- national, regional, local?

What general type of plan is it?

- group- or staff-model HMO?
- network-model IPA or PPO?
- POS plan?

How is it owned?

- Is it private nonprofit? For-profit? Publicly traded?
- Is it a subsidiary of a larger enterprise (e.g., an insurance company)?
- How does it relate to its parent company?

Has it recently merged or consolidated?

How is the plan governed and how is policy made?

- Are consumers included on governing or policy-making bodies?
- Are physicians or other provider representatives included?
- Representatives of the local community?

B. History and Mission

When, how, and why was the plan created?

How do senior officials define its mission? Market? Strategy?

- What emphasis do they place on access to health care? Affordability? Cost controls? Community service? Consumerism?
- How does the plan's stated mission affect operating strategies and practices, in senior management's view?

III. Plan-Level Operating Strategies, Practices

A. Community Initiatives

Does the plan have any community-wide programs targeting, for example, consumer information? education? screening and prevention? other initiatives?

B. Relations with Employers

Do employees or retirees from certain industries or large employers constitute a significant proportion of the plan's beneficiary rolls?

Do services and contract terms negotiated with large employers shape plan operations?

C. Relations with Providers

How does the plan recruit and retain providers?

- How are providers recruited?
- What is the turnover rate among providers?
- What characteristics does the plan look for in providers? How do they assess these characteristics?
- How satisfied are providers with the plan? How do they know?

What does the plan's provider panel look like?

- How many PCPs and specialists are there?
- Are either in short supply, or difficult to recruit?
- How many are in group practice? Solo practice?
- How are they distributed geographically?
- How does the Medicare panel compare to the non-Medicare panel?

What contractual arrangements does the plan make with providers?

- How are providers paid?
- How much financial risk do they bear?
- How is their performance monitored?
- How are approvals, denials, and appeals handled?
- What other contractual arrangements are made with providers?

What services does the plan offer providers?

- Computerized medical records?
- Other centralized information systems?
- Educational programs?
- Quality improvement initiatives?
- Practice management?
- Clinical practice guidelines?
 - Do providers participate in their development?
- Feedback on clinical performance?
- Feedback on patient satisfaction?

How do providers describe the plan's operations and their relationship to it?

- What interactions do they have?
- How do they get information about the plan?
 - About treatment guidelines?
 - About benefits and coverage?
- How does the plan judge provider performance?
 - What provider behaviors does it encourage, reward, or punish?
- How often does the plan deny coverage for treatments providers think necessary?
- How are appeals handled?
- How does this plan compare to others with which providers are familiar?

D. Relations with Beneficiaries

What does the Medicare enrollment look like?

- Age of enrollees?
- Demographic characteristics?
- Where located?

- How do they compare with the Medicare population in the region as a whole?

How does the plan recruit and retain Medicare beneficiaries?

- How does the plan market to Medicare beneficiaries?
- What is its disenrollment rate?
- How does it assess member satisfaction?

What contractual arrangements does the plan make with Medicare beneficiaries?

- What do the Medicare “product(s)” look like?
- How do they compare to other products offered by the plan (e.g., to retirees)?
- What services are covered?
- What co-payments or surcharges do they entail?
- How much choice do they offer enrollees?
- Do they require a PCP gatekeeper?
- How are out-of-plan referrals, or referrals to specialists handled?
- How are approvals, denials, and appeals handled?

What services does the plan offer Medicare enrollees?

- Screening, prevention, or fitness programs, or behavioral incentives?
- Educational materials or programs?
- Informational services, or “ask-a-nurse” hotlines?
- Social services?
- Support groups?
- Customer service initiatives?

IV. Specific Program Information (for identified “best practices”)

A. History

How or why did the program get initiated?

- Was it in response to a specific perceived problem or complaint?
- Was it generated from the literature or by imitation of other programs?
- Did it arise out of someone’s personal philosophy or vision?

What individuals/groups supported or opposed its initiation?

- Was there any especially prominent advocate or opponent?
- Were key stakeholders consulted in any formal way?

Why is the program designed as it is?

- Were any alternatives or modifications considered?
- Were any design decisions especially difficult?

Has the program changed in any way since it began?

- If so, in what ways? Why was this done?

B. Design and Operation

How does the program function?

- What kinds of services are provided?
- What CAHPS dimensions are affected by the services?

How widely implemented is the program?

- Is it plan-wide or specific only to certain products or markets?
- Is it considered experimental?
- Are further expansions possible or likely?

How are program participants chosen?

- Do providers or beneficiaries ask for the service, or is it actively promoted?
- Is there a backlog of requests, and if so, how are service priorities set?
- Are certain groups given high or low priority?

What is the actual client interaction like?

- What specific processes, activities occur between staff and client?
- What materials, if any, are used?
- What other resources does a client-contact staff person have to help solve problems, generate responses?
- How does he/she get access to those resources?

- How much variability is there in the actual service delivered?
- Who determines that variability: client, contact staff or supervisor?

C. Staffing and Management

How does the program fit into the management structure of the plan?

- Who is the supervisor and to whom does he/she report?
- How important is this program to key people up and down the chain of command?

How are budgets and pay levels determined?

- Who decides pay scales? Are there any performance incentives?
- Who sets the overall budget, and how is budget compliance monitored and ensured?

How does the program relate to other aspects of plan operations?

- What is the "interface" like with other functional groups or units?
- How are needs for resources handled?
- Have there been any problems or conflicts?

How many of what kind of staff are involved?

- Is the program run by paid staff or volunteers?
- Is staff time dedicated to this program, or do they combine this work with other duties?
 - If the latter, are there any compensatory workload adjustments?
- Is staff specially recruited for this program?
 - Are there any special educational or other background qualifications?

What kind of training does staff receive?

- Formal or informal? How long? How intense?
- Who does the teaching? What teaching materials, if any, are used?

What are internal communication channels like?

- How does staff gain access to supervisors?
- Are communication channels formal or informal?
- Can front-line staff solve problems directly, or do they have to go through the management hierarchy?

D. Costs and Finances

How much does the program cost?

- How are program costs figured?

How is the program paid for?

- Is the service reimbursable? Does this affect who gets served?
- Are grants or other outside sources of funding involved?

E. Leadership and Culture

How supportive is top management?

How does the program fit with the plan's overall mission?

- Are they seen as competing or complementary efforts?

How does top management evaluate the program?

- Are any numeric performance data collected (costs, productivity, satisfaction, etc.)?
- Have norms or targets been set?
 - Who sets these targets?

F. Overall Evaluation

How do program staff and leaders evaluate the program?

- What quantitative and qualitative methods do they use to measure success?
- What is their subjective assessment?
- Is the program likely to continue?
 - What will determine its viability?
- What changes would staff make in the future?

How have clients responded to the program?

- Have patients responded favorably?
- What evidence supports this observation?
- Do some patients respond more favorably than others?
 - If so, what distinguishes them?

How has staff responded to the program?

- How do both project and non-project staffs feel about it?
- Is there continuing enthusiasm and/or opposition?
- What changes would staff make?

How does senior management view the program's strengths and weaknesses?

- What changes, if any, might top management like to implement?
- Do they plan to extend it to other areas, services, and patients?
 - What would it take for them to make this commitment?

How does the program fit into the plan's overall strategy?

- Is it an isolated experiment or part of an integrated effort?

Is the program or practice replicable?

- Could it be put in place elsewhere?
- Are there factors peculiar to this plan that have made it especially easy (or difficult) to implement here?

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#409 *Perspectives on PPO Performance Measurement from Consumers, PPO Leaders, and Employers* (September 2000). Liza Greenberg, American Accreditation Healthcare Commission/URAC. This report presents findings from meetings with key players in the preferred provider organization (PPO) quality arena, in an attempt to determine if PPOs are capable of reporting standardized health care quality data using nationally recognized measures.

#366 *National Medicaid HEDIS Database/Benchmark Project: Pilot-Year Experience and Benchmark Results* (February 2000). Lee Partridge and Carrie Ingalls Szlyk, American Public Human Services Association. This report summarizes the first year of a project to create national summaries of state Medicaid HEDIS data and national Medicaid quality benchmarks against which each state can measure its program's performance.

#359 *Quality Management Practices in Medicaid Managed Care* (November 10, 1999). Bruce Landon and Arnold Epstein. *Journal of the American Medical Association*, vol. 282, no. 18. In their study of Medicaid plan quality, the authors discover that plans serving predominantly Medicaid beneficiaries were more likely than those with mainly commercial enrollments to provide services to patients that address their special needs, including those related to transportation, literacy, and nutrition.

#296 *Assuring Quality, Information, and Choice in Managed Care* (Summer 1998). Karen Davis and Cathy Schoen. *Inquiry*, vol. 35, no. 2. Citing results from Fund surveys of patients' and physicians' experiences with managed care over the last five years, the authors suggest that minimum quality standards, assurance of choice among quality plans, and comparative information on quality are vital if plans are to be responsive to patient concerns.

#205 *Improving the Delivery of Clinical Preventive Services to Women in Managed Care Organizations: A Case Study Analysis* (January 1997). Nancy Heiser and Robert St. Peter, Mathematica Policy Research, Inc. This paper provides practical information on the types of preventive programs available for women and their potential contributions to women's health. Experiences of knowledgeable health researchers in designing and implementing preventive service programs in managed care settings are highlighted.