

**PERSPECTIVES ON PPO PERFORMANCE
MEASUREMENT FROM CONSUMERS,
PPO LEADERS, AND EMPLOYERS**

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ACRONYMS USED IN THIS REPORT

CAHPS	Consumer Assessment of Health Plans
CM	case management
GAO	General Accounting Office
HEDIS	Health Plan Employer Data and Information Set
HMO	health maintenance organization
JCAHO	Joint Commission for Accreditation of Healthcare Organizations
NCQA	National Committee for Quality Assurance
PPO	preferred provider organizations
TPA	third-party administrator
UM	utilization management
URAC	American Accreditation HealthCare Commission

EXECUTIVE SUMMARY

This paper examines the capabilities of preferred provider organizations (PPOs) to report standardized data on quality of health care using nationally recognized tools, such as the Health Plan Employer Data and Information Set (HEDIS) and the Consumer Assessment of Health Plans (CAHPS). It also presents findings of a series of meetings supported by The Commonwealth Fund to solicit the perspectives of those interested in PPO quality issues. In the summer and fall of 1999, the American Accreditation HealthCare Commission/URAC (URAC) met with consumers, PPO leaders, and employers, who discussed the need for PPO reporting and the perceived cost benefit of public reporting.

URAC also conducted a review of the literature on quality issues specific to PPOs. The review examined topics of quality assessment in PPOs, PPO quality-measurement techniques, and consumer/purchaser needs for quality reporting from PPOs.

Characteristics of PPOs

The term PPO encompasses a very broad spectrum of organizations. Many experts on PPO operations assert that the purpose of PPOs is to provide lower-cost health care and wide choice of providers—not to “manage” care per se. PPOs can be generally categorized into those that operate as “wholesale” or leased organizations; those that have a network and provide some medical management activities; and those that integrate both insurance and network organizations. Wholesale entities lease their network to a payer customer (insurer, self-insured employer, or third-party administrator [TPA]), and do not bear insurance risk. PPOs are paid a fixed rate per member per month to cover network administration costs. Their customers bear insurance risk. PPO network providers are also paid on a fee-for-service basis. Unlike health maintenance organizations (HMOs), wholesale PPOs generally do not have enrollment data or claims data—two major sources of data for performance measurement. The integrated PPO model does bear risk through its insurance functions.

Certain options are often discussed when examining how PPOs can be accountable for measuring and reporting on quality. These include accreditation (e.g., by URAC or the National Committee for Quality Assurance), a review of the structure and processes of an organization, and performance measurement. The most widely known standardized tools used in HMO performance measurement are HEDIS and CAHPS. A few PPOs do use these tools if they have the necessary claims and enrollment data. PPOs that report standardized performance measures represent the most integrated model of PPO or have secured cooperation from their customers to share data and produce

measurements. More frequently, PPOs produce nonstandardized measures of administrative quality and customer service.

Health Services Research Literature

A search of the Medline website reveals that very little has been done to address specifically the performance measurement potential of PPOs. By contrast, voluminous research exists on HMO quality and consumer/purchaser demands for health information in general. Several studies conducted on quality in managed care settings recommend that more attention be paid to differential outcomes related to systems of care.

Literature on consumer demands for information is more generalizable to PPOs. Recent studies show that consumers need to gain a better understanding of how the health care system works before they can use comparative information about plan performance. Consumers place a high priority on information related to how a plan works, costs, ease of access to care, communication, technical competence of health care practitioners, and coordination of care. Moreover, they consider the source of information to be very important. Consumers only rarely use HEDIS data to make choices among health plans. Employer-purchasers, meanwhile, most value data on health plan administration—such as claim turnaround time and financial accuracy—from their health plan vendors. Customer service issues ranked in the second tier of priorities, while HEDIS data and accreditation are less valued by employers.

URAC's Findings

Consumer Organizations

Consumer groups want more structural information on how PPOs work and what consumers' rights and benefits are under PPO systems. They also would like to have standardized information such as CAHPS data. Consumer advocates acknowledge the challenges in producing comparative information between PPOs and HMOs while at the same time encouraging employers and their health plans to cooperate in the development of better measurement systems. They indicated that a top priority is to have more information available to assist consumers in choosing a physician.

PPO Leaders

Industry representatives note that PPOs offer their customers physician network access and cost-effective prices. Many claim that PPOs do not actually "manage" care. Many PPOs do produce performance information for their purchaser customers, mainly administrative data such as customer service and complaints resolution. They report that there is low demand for other information. The few customers that do want standardized information

such as CAHPS or HEDIS collaborate with their PPO vendors to provide more complete claims and enrollment data to enable such reporting. Industry leaders are split on the need for standardized reporting, given the low demand, limited clinical management, and open-access model of PPOs.

Employers

Employers want health care offerings that add value to the dollars they spend on health insurance for their workers. Most employers do not want hands-on responsibility for managing information, nor do they want to pay more for value-added services such as performance measurement for their PPO vendors. Employers do not want performance measurement to interfere with continued open access and geographic coverage from PPOs, or with the level of discounts. Several employers expressed a desire for external organizations such as the National Committee for Quality Assurance (NCQA) and URAC to supply them with a more useful framework for assessing PPO quality. Such a framework could include accreditation or performance measures but ideally would rely on quantifiable, standardized measures.

Analysis and Recommendations

URAC found that no consensus exists with regard to a set of tools that most appropriately measure quality in the PPO setting. Opinions differed on whether PPOs are even managed care organizations and whether they should be held accountable for the quality of clinical care. URAC's findings suggest that reporting on quality must reflect a balance between the interests of diverse users of information, including purchasers, consumers, regulators, and the industry itself. Further, because PPOs offer a wide range of services, requirements for reporting should be tailored to hold PPOs responsible for functions they are contractually accountable for. Future research should address the following issues:

- developing methods to link performance information from various functional units of the health care system—network operations, claims payment, and utilization management—each of which may be a separate vendor;
- identifying methods to convey information more effectively through insurers, TPAs, and employers when health plans are not integrated as are HMOs;
- identifying methods to help consumers select a health plan or provider;
- developing specific protocols for administering CAHPS in unintegrated settings, such as fee-for-service systems or TPA arrangements in which utilization

management, network access, and claims payment are provided by separate vendor organizations;

- analyzing variations in consumer responses to CAHPS questions in PPO and fee-for-service settings;
- improving arrangements among purchasers, TPAs, and PPOs to integrate and analyze PPO network, enrollment, and claims data more efficiently;
- improving data availability to detect at-risk and vulnerable populations in less managed settings;
- establishing lines of accountability to effectively manage high-risk patients in loosely integrated systems.

Progress toward these goals will positively influence health outcomes for patients and the capacity of organizations to measure their clinical effectiveness.

PERSPECTIVES ON PPO PERFORMANCE MEASUREMENT FROM CONSUMERS, PPO LEADERS, AND EMPLOYERS

Introduction

Approximately 90 million Americans are now enrolled in preferred provider organizations (PPOs). PPO enrollment is growing faster than enrollment in health maintenance organizations (HMOs), a reflection of the popularity of a health care insurance model that offers a wide choice of physicians at reasonable cost.¹

Unlike HMOs, however, PPOs have, for the most part, not been asked to report publicly on the quality of their patient care. With the growth of PPOs and managed care in general, this is starting to change. The Federal Employee Health Benefits Program, for example, now mandates that all participating plans, including PPOs, report consumer satisfaction data from the Consumer Assessment of Health Plans (CAHPS). In addition, some states are also now adopting reporting requirements for PPOs. For example, Iowa has directed its department of public health to determine quality-reporting standards for PPOs; Rhode Island mandates that PPOs with more than 10,000 enrollees in the state report data from the Health Plan Employer Data and Information Set (HEDIS); and the New Jersey Department of Health and Senior Services has convened a high-level task force to implement state legislation requiring reporting for all entities that manage care. Many state reporting mandates are modeled after mandates for HMO reporting on quality.

This paper reports on the perspectives of several constituencies affected by health care systems on the issue of PPO quality reporting. It presents findings from a series of meetings held by URAC in the summer and fall of 1999 with consumers, PPO leaders, and employers. At these meetings, participants discussed the need for PPO reporting, the value of reporting (particularly for improving the health of the chronically ill and other vulnerable populations), and the perceived cost benefit of public reporting. URAC's discussion findings are compared with findings from the health services research and industry literature. This paper also addresses applicability of reporting methodologies such as HEDIS and CAHPS, given the data limitations and variations in services offered by PPOs. In the concluding section, the author provides recommendations for research and development activities needed to develop effective approaches to PPO quality reporting.

Background: Characteristics of PPOs and Current Performance Measurement Tools

Defining the PPO

The term PPO encompasses a very broad spectrum of organizations. Many experts on PPO operations assert that the purpose of PPOs is to provide lower-cost health care and

wide choice of providers—not to “manage” care per se. The structure of the majority of PPOs reflects this priority on cost-control and access objectives. URAC classifies PPOs according to three functional divisions, although, in fact, many permutations of these models exist.² URAC’s categories include:

- lease-type PPOs, which consist of a network of providers under contract. The PPO entity then contracts itself to a variety of health care systems such as insurers, TPAs, and self-insured employers. Those customers buy or provide other managed care services themselves.
- managed PPOs, which have a network of providers under contract and offer utilization management (UM) services to at least some customers.
- integrated PPOs, also known as “at risk” PPOs or PPO plans. This type of PPO owns or leases a network of providers and is the only model that insures covered lives and pays claims both in and out of network.

How PPOs Operate

Many PPOs incorporate selected features from the above models to provide services in a wide geographic area. Because they offer a menu of services, PPOs make available different services to different customers; for example, a PPO may process claims for one client but not another. The following discussion highlights some key features of PPOs that affect their care management and quality-reporting strategies.

Financial arrangements. Most PPOs are paid a fixed administrative fee to cover network management expenses. This amount generally ranges from \$4 to \$6 per member per month. Most PPOs do not assume the insurance function or accept risk. The PPO’s customer—the insurer or self-insured employer—assumes the financial risk. A third-party administrator (TPA) often acts as an intermediary or broker between a self-insured employer and its vendors, which may include the PPO network, UM organization, or bill review organization.

Enrollment. Most PPOs do not have “positive enrollment”—that is, they are not provided with lists of subscribers and dependents by their customers. PPOs, rather, are given the names of subscribers without dependent names or, occasionally, are not given any subscriber information at all. PPOs without subscriber information rely on their customers to provide them with information on how often the network was accessed by eligible patients and may conduct audits to verify this information. Amounts per member

per month are calculated on the basis of the number of subscribers multiplied by a “dependent factor” of approximately 2.1 to 2.4.

Benefits. Lease and managed PPO models do not offer benefits. Their customers, the insurers, or employers provide benefits. These PPOs offer the network of health care providers that can be accessed by patients as a part of their benefits package. Those PPOs that conduct UM will review specific procedures against a list of benefits provided by the customer, but often they will not know of other benefits offered beyond those that must be precertified. More so than other health care offerings, benefits that include a PPO network are tremendously diverse. For example, some employers choose not to cover preventive care services or they require patients to exhaust a deductible before covered benefits begin.

Access features. PPOs offer an open-access model of health care delivery. Patients who seek care in-network pay a smaller copayment or deductible but can seek care outside the network without prior authorization. Most PPOs offer a directory of providers to guide patients toward network providers.

Provider arrangements. Many PPOs contract with the greatest number of physicians possible to achieve the largest geographic network of providers. Any provider who will accept the PPO discount is admitted into the network. PPO providers are paid on a fee-for-service basis. Contract terms between providers and the PPO dictate the level of discount applied to provider fees. A few PPOs are selective in developing their network based on factors such as a physician’s specialty, board certification, and utilization profile. Some PPOs “credential” providers by verifying licensure, education, and insurance coverage according to specific protocols. Those PPOs may re-credential providers periodically as part of a quality-management process. Since PPO networks are very large, PPO subscribers often comprise only a tiny percentage of patients on any given provider panel.

Leasing and ownership arrangements. A PPO network is created by a contractual arrangement between the PPO and physicians or health care facilities. The contract specifies the discount available to payers if patients use network providers. The contract may also address access and quality-management obligations between the provider and network. A PPO commonly will expand its geographical scope by leasing preexisting PPO networks in an area in which the PPO wishes to expand. Although the PPO will market the leased network as its own, it must abide by the terms of the original contract with providers. A large number of PPOs combine ownership and leasing to offer a national PPO product.

Bill review. PPOs often process claims, although they do not pay them. (Risk-bearing PPOs do pay claims, but they represent a minority of PPOs.) Through claims processing, a PPO reviews services provided and applies the negotiated discount to the bill. It then forwards the approved bill with the negotiated payment amount to the claims payer (TPA, insurer, or employer), which issues the actual check to the provider. Bill review often allows a PPO to access data on in-network services; the PPO does not see out-of-network claims unless it is a claims payer.

Utilization management. Many PPOs offer UM or case management (CM) services as an add-on product to network offerings. These services are sold as separate products from the network access. Many PPO customers purchase UM or CM services from a separate vendor. Alternatively, customers may provide UM or CM through in-house staff, or not offer those services at all.

Patient contact. Many leased and managed PPOs are marketed under the name of their customer. The patient identification card may provide a phone number to contact the network for assistance in selecting a physician, but otherwise the patient is not aware of the PPO by name. Many PPO customers prefer that PPOs have limited contact with patients. Mailings for health education and health-risk assessment, and even patient satisfaction surveys, are conducted by the customers rather than the PPO, if they are conducted at all.

Quality-Reporting Tools Available to PPOs

Several options are commonly discussed when examining how PPOs can be accountable for measuring and reporting on quality. This section identifies several standardized and nonstandardized approaches to quality measurement in PPOs. It also discusses some of the challenges associated with implementing them universally in PPOs, given the characteristics identified in the prior section.

Accreditation. Accreditation is a review of the structure and processes of an organization through a comparison with national operating benchmarks. Two PPO accreditation programs are in place, one offered by URAC and one by the Joint Commission for Accreditation of Healthcare Organizations (JCAHO). The National Committee for Quality Assurance (NCQA) finalized accreditation standards for PPOs in August 2000. URAC and JCAHO's standards, which apply to PPOs of all models, focus on an organization's network management. NCQA's standards apply to PPO plans that have financial accountability and enrollment information—the more integrated PPO model.

Accreditation is a voluntary process for PPOs. To date, employers have not demanded accreditation to any significant extent. Furthermore, the cost of accreditation has proved to be a barrier to its acceptance. Accreditation has consequently not gained a significant foothold in the PPO market. Each accrediting organization has struggled to find the appropriate “bar” for PPO standards, one that is rigorous but not so difficult as to pose a barrier to voluntary participation.

Clinical process measures. HEDIS, designed for HMOs and promulgated by NCQA, is the most widely known standardized tool for the collection of health plan data.³ Among other measures, HEDIS specifies criteria for reporting on the clinical effectiveness of care delivered to a representative sample of patients. The HEDIS model presumes that the health plan is accountable for delivering care measured by HEDIS indicators, and that HEDIS information should drive quality improvement.

A few integrated-model PPOs report modified HEDIS data. Those that do report make adjustments to accommodate the open-access PPO model, since HEDIS presumes that a single primary care provider is accountable for most aspects of care. The majority of PPOs do not have complete claims data to produce even modified HEDIS data and do not have the enrollment information to determine which population should be considered in producing performance indicators. HEDIS data may not have the potential to drive quality-improvement initiatives in PPOs, since not all patients enrolled in PPOs have benefits for services measured by HEDIS. Moreover, with few patients in any one physician practice, PPOs have limited leverage to change provider behavior.

Administrative process measures. Many PPOs report on their administrative performance to customers. Administrative measures typically address claims-processing turnaround time, timely issuance of identification cards, and customer service, including telephone response time. The cost of administering the program, and UM “savings,” is also routinely reported to customers. Some commercially developed software products enable PPOs to report on access measures and utilization of services as well.⁴ Administrative data are not standardized.

Administrative reports do not address “quality of care,” that is, the capacity of an organization to improve health outcomes. Research clearly shows, however, that administrative information is very important to purchasers and patients. Developing standardized tracking methods and linking this information to quality of care remains the key challenge for PPOs.

Survey tools. Surveys can be used to measure both the processes and outcomes of care. In recent years, patient surveys have been adopted as a method to examine patient experiences with the health care system. The CAHPS survey instrument was developed and designed to compare patient experiences across any type of health system and across many health plans and is intended to help patients differentiate among plans.⁵ CAHPS's developers, however, recommend that the survey be administered in plans with roughly similar benefits packages.⁶ The survey can be administered by states, large purchasers, or plans themselves. NCQA has produced a CAHPS administration protocol for use in the HMO and PPO accreditation process.⁷ URAC's standards credit PPOs with compliance with its requirement for a quality-improvement project if they administer CAHPS. The Foundation for Accountability (FACCT) is currently testing a survey addressing patient experiences receiving care for chronic conditions.

PPOs that do not have enrollment information could not derive a sample for surveying eligible individuals (although most PPOs capture enough patient information to be able to survey individuals who have had a UM encounter). Widely varying PPO benefit levels increase the chances that differences among organizations will be the result of patient dissatisfaction with benefits, rather than their experiences with covered services. In addition, CAHPS may have limited value in facilitating comparisons among health plans if the PPO and its competitors use the same networks of providers, as is often the case.

URAC's PPO Quality-Reporting Initiative

In the summer and fall of 1999, URAC conducted a project funded by The Commonwealth Fund to examine the use of CAHPS and other quality-measurement tools to evaluate access to and satisfaction with PPO services. The goal was to assess the priorities of consumers, PPOs, and employers regarding performance information. This data was compared with actual performance-measurement activities and with the capability of PPOs to produce standardized measures. Project activities included:

- meetings with consumer organizations, PPO industry leaders, and employers to discuss priorities for PPO quality reporting;
- a review of the literature on PPO performance reporting research, including demands for reporting;
- publication and dissemination of this paper on techniques for quality reporting, including CAHPS, in PPO systems; and

- development of recommendations to the URAC leadership on how performance reporting could be incorporated into the PPO accreditation process.

Specific questions posed to consumers, employers, and PPOs included variations (depending on the perspective of each group) of the following:

- What elements of quality reporting are of highest priority?
- What factors influence adoption and use of CAHPS and other quality reporting in PPOs?
- What adaptations would make CAHPS and other quality reporting more applicable and effective in PPO settings?
- How can PPO quality-improvement processes be used to improve access to care, particularly for vulnerable and chronically ill populations?
- What data and information systems are needed to facilitate improved access and delivery of care?
- What voluntary and regulatory approaches can encourage development of quality systems?

Review of Literature on PPO Quality

URAC first endeavored to identify health services research literature that might suggest a direction for PPO quality reporting. URAC also examined literature on the informational needs of various constituencies of health care organizations. Consumers, health care providers, payers, and health care organizations each have differing perspectives on what to measure and who should measure it.⁸

A Medline search to identify health services research in the area of PPO quality reveals that very little has been done to specifically address the performance measurement potential of PPOs. This stands in contrast to the voluminous research on HMO quality and consumer/purchaser demands for health information in general. Few media resources address PPO quality, although there are numerous articles in the popular press each year comparing quality of HMOs. For example, rankings of HMOs based on HEDIS scores and other quality indicators appear regularly, and there are several websites providing similar information.^{9,10}

The literature specific to PPOs is sparse. An article by Dean Smith reported that PPO networks had the effect of reducing overall use of health care services.¹¹ A comprehensive review by Miller and Luft on quality in managed care determined that further research was needed to address quality issues regarding PPOs.¹² Several articles generated by the large-scale Medical Outcomes Study group concluded that greater attention is needed to identify differences among systems of care and the implications for health outcomes.^{13,14}

The literature on consumer needs for health plan information in general does provide some guidance on the direction of PPO reporting. Research has identified a gap in consumer understanding of the health care system in general and health plan performance information specifically.¹⁵ Consumers seem to have difficulty understanding performance information as it is now presented and need more information about how the health care systems work before they can understand and use comparative information on plans.¹⁶ A review article by Edgman-Levitan and Cleary states that health care consumers want and would use evaluations of health plans. Overall, consumers are interested in how a plan works, out-of-pocket costs, ease of access, communication and information, competence of health care practitioners, and coordination of care. They do not want evaluations conducted by health plans, insurance companies, or the government but do want evaluations from people who are “like them.”¹⁷ Recent studies show, however, that consumers rarely use HEDIS data for decision-making about health plans and only use CAHPS data to validate health plan choices they have already made.¹⁸

Much of the information on employer objectives for PPO quality information is found in the managed care trade press, rather than health services research literature. Again, the literature speaks to managed care purchasing in general, rather than PPO-specific needs. A 1998 study by Deloitte and Touche, for example, found that employers value claim turnaround time and financial accuracy most highly. Customer service issues ranked in the second-tier of priorities, while HEDIS data was one of the least-valued performance standards required by employers.¹⁹ This finding is consistent with Gabel et al., who showed that employers rarely use accreditation and performance data in selecting an HMO.²⁰ Other surveys have shown that employee satisfaction with the health coverage offered and cost competition are two major factors in employers’ decisions on whether to offer a PPO option to their workers.²¹

More research has been done on the objectives of purchasing cooperatives and large employers than on the objectives of other employer purchasers. These cooperatives, however, are not necessarily typical of all health care purchasers. Price control is the

primary objective of insurance cooperatives, while quality improvement is a second-generation goal.²² A study by the U.S. General Accounting Office (GAO) finds that some large purchasers are demanding and receiving performance information ranging from CAHPS data to modified HEDIS scores. The GAO believes that the ability to compare PPO plans will evolve as performance measures become more sophisticated.²³ These findings are consistent with other reports that have determined that large purchasers and purchasing coalitions are driving quality reporting.²⁴

URAC's Findings

Consumer Meetings

URAC invited a convenience sample of representatives of consumer organizations to provide input on what kind of information they desire from PPOs. Participants were provided with a brief orientation on the structure and function of PPOs and on information potentially available from the CAHPS survey. They were invited to comment on what information they would like to have from PPOs, including standardized data such as from CAHPS. The attendees were asked to assist URAC in determining how costs should be considered when developing requirements for PPO quality reporting.

The consumer organizations identified the following priority areas for information from PPOs:

1. **Structure.** Participants in URAC's meeting agreed that structural information is an important baseline, with a focus on structural elements that affect patients. For example, PPOs should report information on the grievance and appeals process, on information systems related to care management capacity, on characteristics of populations or groups served, and on disease management and other special programs that affect certain populations.
2. **Satisfaction.** The group agreed that PPOs should use the CAHPS survey to address issues of patient satisfaction. Because the same tool can be used in any health system, responses would be directly comparable with HMO results.
3. **Administrative and service issues.** The group acknowledged the value that both consumers and purchasers place on the efficiency of administrative services. Participants recommended that PPOs should report on a standard set of administrative measures, such as claim turnaround time and accuracy, telephone response time, and customer service.

4. Process and outcome measures. The group strongly endorsed the value of having HEDIS and other performance measures that allow comparisons between HMOs and PPOs. They recognized the methodological issues that make comparisons difficult at this point but urged that process measures be developed that do capture information on quality in a comparable way. The group concluded that since consumers have different information needs at different stages in their lives, specific information should be available when consumers seek it out.

The consumer focus group generated findings consistent with the literature and helped identify priorities for improving performance information from PPOs in the future. The meeting participants recognized that improved reporting would have to be addressed by purchasers and PPOs cooperatively. Employers, for example, have to cooperate to improve enrollment data. PPOs need to develop better information systems to track enrollment data, and they need to produce information on age, sex, race/ethnicity, and disability status to use in quality assessments. Consumer organizations also recognized that available benefits may affect performance and outcomes, and that benefit selection is controlled by employer/purchasers. The consumer representatives emphasized the importance of provider-level information and recommended that attempts to develop quality data to guide patients' choices of physicians be continued.

PPO Meetings

In a separate meeting, URAC invited a convenience sample of approximately 25 PPO industry leaders, including medical directors and chief executive officers, to discuss implementation of the CAHPS survey and other quality measures. Participants were selected by contacting nationally known PPOs and the American Association of Preferred Provider Organizations and by asking known contacts for recommendations. URAC ensured that PPOs of many model types, plus those that report data and those that do not, were represented at the meeting. The session included an overview of the CAHPS survey by its developers and presentations from PPOs currently using the survey.

Of the PPOs represented in the meeting, a number currently generate performance information using both company-specific reports and national tools. Those that use standardized tools such as HEDIS often do so in collaboration with a specific customer, which cooperates by providing enrollment and claims data not otherwise available to the PPO. The impetus for producing performance information generally comes from large purchasers or regulators. Those PPOs that do not report standardized information say that purchasers have not demanded such information.

The PPO group was asked to develop priorities for producing performance information. Participants discussed specific performance measurement tools and responded to some of the comments made in the consumer meeting.

CAHPS. Several PPOs had experiences using CAHPS, and several use it on an ongoing basis. PPO leaders recognized that CAHPS has the potential to benchmark customer satisfaction and care experience data against national data. However, CAHPS has limited value for PPOs because responses do not assist the PPO in identifying quality-improvement opportunities. Participants felt that the expense of collecting performance data necessitates that it be useful to the PPO for improving quality, not just for drawing comparisons with other organizations.

They were also concerned that consumers respond to questions based on distinctions not under the PPO's control, such as differences in benefits.^a The PPO representatives believe that employers are the most appropriate party for administering CAHPS, since responses can assist employees in making comparisons among the options offered by health plans. The group noted that questions developed by individual PPOs that are specific to the PPO's quality-improvement objectives can be added on to the CAHPS survey, which improves the instrument's utility. PPOs suggested that a new instrument be developed to gauge the experience of payers with PPOs, since payers are their primary customer.

Administrative measures. The group also discussed use of administrative measures, including those related to claims turnaround and telephone responses. Payers and consumers each have an interest in different types of measures—payers in those measures concerning financial management, consumers in those concerning customer service. PPO representatives believe in the value of administrative measures, because these reflect the scope of control and services that PPOs offer to their customers. They believe, for instance, that grievance and appeals data are an important component of quality assurance for customers and patients.

HEDIS. Lastly, the group discussed issues relating to HEDIS measures. PPO representatives noted that PPOs are organized to provide open access to patients, not to tightly manage care. Many PPO leaders assert that choice is an effective alternative to providing clinical performance measures, since patients can seek out the physician they

^a Developers of CAHPS claim that the tool is benefit neutral, but PPOs routinely comment that consumer responses and open-ended comments reflect differences related to benefits and payment differentials, which are determined by the purchasers, not the PPOs.

want. Some members of the group questioned whether PPOs should be held accountable for clinical and outcome measures, believing that HEDIS presumes a higher level of clinical management and financial controls than exists in the majority of PPOs. In general, PPOs have more varied benefit offerings than HMOs, do not attempt to influence the behavior of physicians and other health care providers, and have uneven access to data. This complicates production of HEDIS measures. HEDIS data produced by PPOs is not directly comparable to HMO HEDIS data. PPO participants also commented that payers are not interested in HEDIS data and are therefore not willing to invest in production of the data.

Members of the focus group made several recommendations to guide future development of performance measures:

1. Performance measures must address differences in plan structure in fully insured and self-insured markets as well as differences in PPO functional models.
2. Performance measures must be more closely tied to payer needs, since payers will not accept higher costs for performance information they do not want.
3. Performance indicators for PPOs should focus on cost savings and measuring provider access.
4. With increasing demand from regulators for performance information, more uniform definitions and requirements are needed to reduce the burden and cost of reporting for national organizations.

Employer Meetings

As a final component of its qualitative research into perspectives on PPO quality, URAC met with a group of large employers. The meeting was organized by the Managed Health Care Association, a membership group comprising large, mainly self-insured employers with an interest in health care issues. The session consisted of a presentation on the status of PPO quality reporting and an open dialogue with employers to discuss their goals for information on quality.

The employers who participated expressed frustration with managed care in general, and with PPOs specifically. Although they value PPOs for their wide geographic access and their discounted fees, employers gave PPOs low marks for managing the quality of health care and providing information on quality. A few employers require reporting

on quality of care or demand raw data, which they then analyze to assess PPO quality. Most employers, however, indicated that they neither have the expertise to manage performance information measuring clinical outcomes nor consider doing so to be their top priority. They want PPOs to “add value” by offering more integrated, outcomes-oriented health care. At the same time, employers said it would be difficult to justify paying additional costs for such value-added services.

Several employers in the meeting stated that their firm either administered CAHPS directly or required CAHPS data from PPO vendors. While expressing support for using CAHPS data to compare HMO and PPO trends, employers nevertheless are reluctant to add on costs to support CAHPS administration in PPOs. One employer pointed out that, ultimately, patients are most interested in the quality of health care providers and want information that will help them choose a provider; information about the health services delivery system is less important to them. In addition, meeting participants questioned the usefulness of the distinctions that CAHPS makes between different health care organizations, since most organizations use overlapping provider networks.

The key priorities that emerged from the employer group—most of which did not address performance indicators—include:

1. **Value.** Employers want more value from PPO offerings and in the information provided to them on performance.
2. **Cost.** Employers want continued cost control from PPOs. Employers are not willing to take on added health care costs for the express purpose of quality measurement.
3. **Demand for PPOs.** Employers want continued availability of open-access health coverage models.
4. **Access.** Employers are pleased with the geographic coverage offered by PPOs, especially their availability in rural areas and in markets with low HMO penetration.

Several employers stated a desire for external organizations, such as NCQA and URAC, to provide a more useful framework for assessing quality in PPOs. That framework could include accreditation (a review of organizational structure and process) or performance measures (a review of care processes and outcomes). Ideally the

framework would rely on quantifiable measures that permit comparisons of the outcomes of different organizations.

Analysis and Recommendations

At the conclusion of this preliminary review of PPO quality issues, URAC was struck by the seeming contradictions inherent in the health care system:

- Consumers and payers are satisfied with PPOs—as evidenced by growing enrollment—yet have little understanding of how they operate or what constitutes good care in a PPO context.
- PPOs are considered to be managed care organizations, yet for the most part manage only cost through discounted fees.
- Employers are disappointed with the value they derive from the health care system yet are reluctant to drive the system through payment incentives or quality management.
- Tremendous resources are spent on accountability and performance measurement, yet research shows that few are using accountability data for decision-making.

URAC also observed that while PPOs are lumped into a single category, there are in fact significant functional differences among them. In this section, URAC analyzes responses to the questions initially posed to the three constituency groups involved in this study. Along with the analysis, the author speculates on how the health care system might evolve and identifies key areas for future research. For all types of performance indicators, URAC recommends that the needs of the end-user of information be considered, such that information can be used more effectively in decision-making than it is now. URAC's recommendations for specific entities are categorized beginning on page 17 of this report.

Which elements of reporting are of highest priority?

URAC found no consensus either within or among the constituency groups of PPOs, consumers, and employers regarding which elements should be reported. For PPOs, their contractual obligations and availability of data are two factors that influence quality-reporting capability. URAC's findings suggest that reporting on quality of care must reflect a balance between users' diverse needs for information—be the user an employer, regulator, consumer, or provider. Functions of a PPO organization must drive the information it produces. Future research should concentrate on linking performance

information from various functional units of the health care system—network operations, claims payment, and UM, each of which may be a separate vendor—in order to provide a more comprehensive view of quality.

Helping consumers understand how PPOs operate should be an initial goal. This may mean placing greater emphasis on how health plan benefit information is conveyed to consumers through insurers, TPAs, and employers. Both employers and consumers need to understand the advantages and disadvantages of PPO coverage. Also needed are strategies to help consumers make informed choices regarding their health care provider.

What factors influence PPOs to use CAHPS and other quality reporting instruments, and what adaptations would make these instruments more applicable to and effective in PPO settings?

URAC found that employer/purchaser and regulatory demands were influential in encouraging use of standardized tools such as CAHPS. However, these demands do not always recognize the data limitations or operational diversity that exist across PPOs. Comparing health plans with similar benefit packages—as CAHPS’s developers recommend—is problematic for PPOs because different employers can offer very different benefit levels. The value of CAHPS data would be increased if the survey addressed issues relevant to quality improvement within the PPO.

URAC recommends that CAHPS developers design specific protocols for administering CAHPS in unintegrated settings such as fee-for-service systems or plans comprising multiple contracted vendors serving a self-insured employer. Further research is needed to analyze variations in consumer responses to CAHPS questions in HMO, PPO, and fee-for-service settings.

How can PPO quality-improvement processes be used to improve access to care, particularly for vulnerable and chronically ill populations?

A few PPOs report integrating their open-access model of care delivery with a disease-management program to more actively manage care of high-risk individuals. Most PPOs, however, take a passive approach to chronic disease management. In most, a lack of claims and enrollment data presents a barrier to the identification and active management of high-risk cases. URAC believes that chronic care management could be improved through greater coordination among PPOs, employers, insurers, and TPAs. Establishment of electronic data interchange standards would promote capacity to merge and analyze data from multiple sources. In the interim, PPOs could be expected by customers to share sentinel data from UM encounters to flag high-risk cases. PPOs could also use Internet and electronic approaches to improve chronic illness management among network

providers. Such coordination could be promoted through accreditation standards. PPOs could also be encouraged to develop Internet-based health education and risk assessment programs aimed at patients—relatively low-cost approaches to addressing chronic care issues.

What kind of data and information systems can facilitate improved health care access and delivery?

As noted above, many improvements in care management are contingent upon improvements in data and information management in PPOs. At a minimum, improved enrollment information must be an objective of relationships between PPOs and purchasers. Such data systems could be used to identify at-risk and vulnerable populations. Purchasers, TPAs, and PPOs should develop arrangements to integrate and analyze PPO network, enrollment, and claims data more efficiently.

Conclusions

Currently, there is a dearth of performance information from PPOs in the areas of structure, process, and outcomes. The prospect of widespread implementation of performance reporting in PPOs is limited unless the current incentives for producing performance data change and unless payers and consumers exhibit greater demand for this information. At present, PPO performance reporting is spurred primarily by regulatory requirements and the requirements of a few large employers and purchasing coalitions. Consistent demand for performance reporting will only be generated when the information more effectively meets the needs of diverse users.

URAC recommends that a core set of information be developed for PPO reporting that succinctly reflects the priorities of patients and all those who pay for health services. Performance measurements should reflect the functions of the organization producing data and should not present a barrier to innovation and flexibility in design of health care systems. Performance information, then, may vary based on the model of the PPO providing the reports and its areas of contractual responsibility. A standardized, integrated system for exchanging data among various health care vendors is needed to facilitate reporting in today's loosely integrated health delivery systems. Improved performance reporting will necessitate greater cooperation and coordination among PPOs, employers, and insurers.

RECOMMENDATIONS

1. Recommendations for Payers: Performance Information That Should Be Available from All PPOs

Structural Information

Payers should require that information in a standard format is available from each health plan using a defined network. Information should include how the network is constructed and rules for accessing its benefits in and out of network; customer service options, including Internet- or telephone-based assistance; and the process for remedying a problem, complaint, or grievance. Accrediting organizations should promote standardization of structure and process information by working with major players such as the Office of Personnel Management (OPM) and the Health Care Financing Administration (HCFA) to develop a standard information format and by promoting it through accreditation requirements.

Patient-Reported Information

URAC recommends that payers use CAHPS as the preferred tool for assessing patient experience and satisfaction with their PPO health plans. URAC further recommends that CAHPS be administered by the entity that provides health benefits.

Clinical Information

Accountability for preventive care services and care for chronic illnesses varies tremendously among PPOs due to differences in structure and benefit levels. URAC recommends that payers assess PPO contractual obligations as the basis for determining which PPOs should be held accountable for reporting on clinical interventions.

Customer Service Information

URAC recommends that patient experiences be assessed through the standardized CAHPS questions relating to customer service and claims handling. Payers should also require PPOs to track and manage customer service quality based on the PPOs functional responsibilities.

2. Recommendations for Accreditors: Performance Standards That Can Be Linked to the Accreditation Process

Structural Information

As noted, accreditors should promote standardization of structure and process information by jointly developing a format for standardized information and promoting it through accreditation requirements.

URAC recommends that at minimum, PPOs develop capabilities to manage enrollment data and request such data in contract negotiations. However, URAC recognizes that PPOs have little leverage to obtain data from their customers, since customers set the contract terms. Accreditors could promote data improvements through voluntary standards for data integration and management.

Patient-Reported Information

Accreditation processes should direct PPOs to participate in CAHPS but, at the same time, should recognize that CAHPS could be administered by one of many entities, including states, employers, or PPOs.

Clinical Information

Accreditation standards should establish benchmarks for clinical management appropriate to the PPO model being evaluated. Some standards may be applicable only to PPOs with contractual obligations to provide certain services, such as case management. For example, depending on the level of PPO integration, accreditation standards might require PPOs to:

- use claims data to flag cases of chronic illness for more intensive follow-up;
- coordinate between PPOs and payers to identify the chronically ill;
- channel certain patients to referral outreach programs; and
- adopt health risk–assessment strategies, particularly as data systems improve.

Customer Service Information

Accreditation standards should recognize the two customers of PPOs: patients and payers. Standards should address customer service for patients by requiring CAHPS participation, including use of administrative and customer service questions, as noted above. Standards should address customer service for payers by requiring a standard reporting format and verifying performance on key elements of the payer contract: claims turnaround time; phone-response time; claims accuracy, and other administrative performance standards.

3. Recommendations for Health Services Researchers

Provider Performance

Health services researchers should join with accreditors, payers, plans, and providers to improve provider-level performance measurement initiatives that will better support consumers' ability to make an informed choice of physician.

Patient-Reported Information

Health services researchers should develop a “crosswalk” to illustrate how to interpret and compare CAHPS data collected at the state, employer, and individual-plan level. This will facilitate administration of CAHPS at the appropriate level for comparison and mitigate some of the issues related to high cost of administration for any individual plan.

Researchers should also develop an algorithm for PPOs to indicate which entity (network, insurer, TPA, or other) is the appropriate one to administer the CAHPS survey at the plan level. The algorithm would support administration of CAHPS by the entity most accountable for improvements.

Clinical Information

Health services researchers should develop models for reporting on clinical care for delivery systems in which insurance and network functions are contractually related but not integrated (e.g., managed and lease-model PPOs). Future HEDIS modifications should be made with consideration to developing methodologies that do not rely on a primary care provider or medical record review (e.g., those that use administrative data only), such that reports will be more comparable between HMO and PPO systems of care. Health services researchers should invest more attention in understanding the quality information needs of employers/payers, perhaps through development of a standard survey of employers similar to CAHPS.

4. Recommendations Relating to the Regulatory Environment

URAC recommends that its leadership develop a strategy for educating regulators about how PPOs operate and about options for improving the accountability of PPOs of each model.

RELATED PUBLICATIONS

In the list below, items that begin with a publication number are available from The Commonwealth Fund by calling our toll-free publications line at 1-888-777-2744 and ordering by number. These items can also be found on the Fund's website at www.cmwf.org. Other items are available from the authors and/or publishers.

#395 *Early Implementation of Medicare+Choice in Four Sites: Cleveland, Los Angeles, New York, and Tampa–St. Petersburg* (August 2000). Geraldine Dallek and Donald Jones, Institute for Health Care Research and Policy, Georgetown University. This field report, based on research cofunded by The Commonwealth Fund and the California Wellness Foundation, examines the effects of Medicare+Choice—created by the Balanced Budget Act of 1997—on Medicare beneficiaries in four managed care markets.

#394 *Medicare+Choice in 2000: Will Enrollees Spend More and Receive Less?* (August 2000). Amanda Cassidy and Marsha Gold, Mathematica Policy Research, Inc. Using information from HCFA's Medicare Compare consumer-oriented database of Medicare+Choice plans, this report provides a detailed look at changes in benefits offered under Medicare+Choice in 1999–2000, focusing on benefit reductions and small capitation rate increases that are shifting costs to beneficiaries.

#393 *What Do Medicare HMO Enrollees Spend Out-of-Pocket?* (August 2000). Jessica Kasten, Marilyn Moon, and Misha Segal, The Urban Institute. Medicare+Choice plans are scaling back benefits and shifting costs to enrollees through increases in service copayments and decreases in the value of prescription drug benefits. This report examines the financial effects of these actions on Medicare managed care enrollees.

#380 *Educating Medicaid Beneficiaries About Managed Care: Approaches in 13 Cities* (May 2000). Sue A. Kaplan, Jessica Green, Chris Molnar, Abby Bernstein, and Susan Ghanbarpour. In this report, the authors document the approaches used and challenges faced in Medicaid managed care educational efforts in 13 cities across the country.

#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.

Do Consumers Use Health Plan Report Cards? (December 1998). National Committee for Quality Assurance. This report shows that, while employees who use health plan quality report cards find them valuable when choosing a plan, many employees have not yet learned to take advantage of them. Copies are available from the National Committee for Quality Assurance, 2000 L Street, NW, Suite 500, Washington, DC 20036, Tel: 202-955-3500.

#298 *Assessing Quality in Managed Care: Health Plan Reporting of HEDIS Performance Measures* (September 1998). Donna O. Farley, Elizabeth A. McGlynn, and David Klein, RAND Corporation. This policy brief examines health insurance plan reporting patterns for Health Plan Employer Data and Information Set (HEDIS) measures, identifying which factors contribute to plan participation in the National Committee for Quality Assurance's Quality Compass and how the present system could be improved.

#293 *When Employers Choose Health Plans: Do NCQA Accreditation and HEDIS Data Count?* (August 1998). Jon R. Gabel, Kelly A. Hunt, and Kimberly M. Hurst. The authors suggest that a modest initiative on the part of the federal government to educate employers and their advisors, brokers, and benefit consultants would improve the use of Quality Compass and NCQA accreditation information.

#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.

NOTES

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