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New Assessment Program for PPOs

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The National Committee for Quality Assurance (NCQA) has for nine years rated health maintenance organizations (HMOs) based on customer satisfaction, access and availability of care, health plan stability, use of services, cost of care, and effectiveness of care. This year, the NCQA will embark upon a similar assessment program for preferred provider organizations (PPOs). This article will explain the rationale behind a rating system for PPOs and compare the performance measurements used to rate PPOs with those used for HMOs.

Why PPOs?

In 1998, for the first time, PPO plan enrollment exceeded HMO plan enrollment. Approximately 100 million Americans are covered by PPOs. The reason for the rising popularity of PPOs is probably due to the increased choice: there are fewer restrictions on specialist care and PPOs offer better out-of-network coverage than HMOs. The NCQA thus believed the time was right to measure the quality of PPOs.

The Measurements

The tools to measure quality for PPOs will not be as stringent, at least initially, as those used to measure HMOs. PPOs will not be required to submit Health Plan Employer Data and Information Set (HEDIS) effectiveness-of-care results that HMOs are required to submit for accreditation. These measurements, covering such services as antidepressant medication management, cervical cancer screening, and comprehensive diabetes care, involve a thorough analysis of administrative, enrollment, and medical record data. For this reason, most companies with large data warehouses utilize a third-party vendor to handle compliance with HEDIS effectiveness-of-care requirements.

Another component of measuring quality of care for managed care organizations is the use of customer satisfaction surveys. PPOs will be required to comply with this measure. These surveys, known as CAHPS (Consumer Assessment of Health Plans), assess patient satisfaction with the experience of care. A random sample of members is asked about their overall satisfaction with the plan and its doctors; key areas such as claims processing, customer service, and physician communication are targeted. Managed care organizations are required to contract with an NCQA-certified vendor to administer the surveys, to ensure unbiased reporting.

PPOs must submit a CAHPS survey to NCQA every year in order to maintain accreditation. Evaluation is done by product line (commercial and/or Medicare). The results are then compared to national benchmarks and thresholds based on previous surveys. There are three possible scores: Accredited, Provisional, and Denied. Accredited means a score of 65-100%, Provisional signifies a score of 55-64%, and Denied is a score of 54% and below. Only PPOs earning Accreditation status will receive an accreditation seal from NCQA.

Conclusion

The accreditation standards for PPOs are still in the nascent stage. At the time this article was written, a draft of the accreditation program could be found on the NCQA Web site *www.ncqa.org* for public comment. As more employers provide PPOs as an option for their employees, there will be a rising demand to know how well the doctors in those PPOs perform comparable to doctors in other managed care organizations. The NCQA has taken that first step in objectively measuring the quality of care of PPO plans.

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