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Health Plan Quality: Factors Influencing Hospital Participation in Health Plans

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HEALTH PLAN QUALITY: FACTORS INFLUENCING HOSPITAL PARTICIPATION IN HEALTH PLANS

BY

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Committee Chair: Walter J. Jones, Ph.D.
Committee Members: W. David Bradford, Ph.D.
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The professional and popular literatures are full of reports of surveys and studies purporting to rate health plans. Health maintenance organizations and other organizations are surveying member satisfaction. Accreditation of health plans is receiving increased attention. Interest is growing in plans' performance in the areas measured by the Health Plan Employers' Data and Information Set (HEDIS). The factors measured in current ratings and accreditation systems are not important to hospitals for evaluating health plan participation. There are factors in a health plan's performance that are important to and either beneficial or detrimental to hospitals. This paper proposes factors upon which health care plans should be evaluated and rated to measure their "business partner quality" from the hospital perspective.

C H A P T E R I

INTRODUCTION

Introduction

The June 24, 1996, issue of Newsweek ran, as its cover story, a report on its national survey of health maintenance organizations (HMOs) replete with ratings of 43 HMOs (Spragins, 1996). The author, Ellen Spragins, followed up with a list of 10 tips for picking HMOs, published in Business & Health in October 1997 (Spragins, 1997).

The August 19, 1996, edition of CNN Financial News Network reported on its own survey and ratings of HMOs. In its August 1996 issue, Consumer Reports weighed in with its cover story on health plan ratings—Part 1 of a series, rating 37 HMOs and 14 preferred provider organizations (PPOs) ("How good is," 1996).

U. S. News and World Report had its own cover story on September 2, 1996, claiming "the first rigorous assessment of quality, state by state." (Rubin, 1996, p. 52). The June 13, 1997, issue of the Wall Street Journal published its guidance on how to assess an HMO's quality. While largely

touting the measures of the National Committee for Quality Assurance (NCQA), the Journal nonetheless added its six prescriptions to the quest for managed care plan quality (Jeffrey, 1997). Shortly thereafter, Parade Magazine, the popular newspaper Sunday supplement, offered its own guidance on how to get quality from an HMO (Ubell, 1997).

The efforts of the NCQA accreditation process and the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) process for the accreditation of health plans and integrated delivery systems point to the considerable interest that exists in the accreditation of health plans. NCQA began publishing results of its quality surveys in August 1996, in a publication entitled Quality Compass. The second annual Quality Compass report was released in September 1997 and the third edition in September 1998.

Evidence continues to mount of the growing interest in plans' performance in the areas measured by the Health Plan Employers' Data and Information Set (HEDIS), a set of measurements developed by some of the nation's largest employers for evaluating their health benefit plans. The NCQA Quality Compass reports are based on HEDIS data reports. Benefit consulting firms regularly develop various methods of rating healthcare plans for the benefit of their clients, and organizations, whose sole existence is dedicated to health plan accountability, such as the

Foundation for Accountability (FACCT) of Portland, Oregon, are making their presence known.

All of the surveys and ratings ostensibly seek to measure the elusive "quality" of health plans. These are all admirable efforts to evaluate and rate plans and, thereby, hold them accountable for their performance. However, some analysts are critical of the methodologies used in some of the surveys.

Some of the surveys conducted by managed care plans themselves are criticized as of having pro-plan bias built into their survey methodology (Reese, 1997). Even the highly regarded efforts of NCQA have received criticism from managed care plans over their fairness in accepting unaudited data from some plans and comparing it to audited data from other plans (Kertesz, 1997).

In a comparison of seven health plan report cards available in the Fall of 1996, Scanlon, Chernew, Sheffler, and Fendrick (1998) observed that "the diversity of approaches to report card construction reflects the lack of agreement on what constitutes quality of a health plan…" (p. 6). The Department of Insurance of the State of Idaho, in its World-Wide Web site discussion of quality ratings also points out its perceptions of the deficiencies of NCQA's efforts ("Quality ratings," 1997).

In addition to these criticisms, most of the rating and accreditation efforts to date have heavily weighted their

definitions of quality and their measures of performance of the plans with either the consumer or payer perspective. Even the Weiss Ratings, Inc., reports on HMOs, which focus primarily on financial performance and condition, are of most interest to payers or consumers with an interest in the financial stability of a plan.

There is, of course, great value to consumers and payers in such measurements; however, the factors measured in the various rating and accreditation schemes are of little value to hospitals and other providers in differentiating between high quality plans and low quality plans from the provider perspective. There are plan performance factors that can be beneficial to providers if plan performance is good or detrimental if plan performance is poor. In some cases, improving a plan's performance under the various ratings and accreditation schemes can result in increased burdens being imposed by the plan on providers. Indeed, according to the June 24, 1996, issue of Newsweek, "HMOs—and their cousins, preferred provider organizations (PPOs) and point-of-service plans (POS)—are scrambling to dominate markets so that they can wring more costs out of doctors and hospitals" (Spragins, 1996, p. 57).

One of the negative impacts of managed care health plans is an increased administrative burden. To the extent that the health plans require hospital participation in extensive utilization review procedures and impose onerous

claims processing requirements, directly or indirectly, the plans increase the administrative cost of the hospital providers. One study by HCIA, Inc., the large health care information organization, found that high managed care enrollment in markets correlates with higher overhead expenses in hospitals. The study of 1997 data indicated that the median overhead expense ratio at hospitals in high managed care enrollment markets was higher than the median of all U.S. hospitals and was higher than hospitals in lower managed care penetration markets. The difference between the median for all hospitals and the median hospitals in high managed care enrollment markets was $884 per discharge or 47 percent higher ("Hospitals pay," 1998).

In a similar study, the Center for Healthcare Industry Performance Studies (CHIPS), found that top-performing hospitals in high managed care penetration markets do more poorly on many key financial ratios than high-performing hospitals in markets with lower managed care penetration. In comparison of 17 key financial ratios, CHIPS found that among the top quartile hospitals, high managed care penetration in their market correlated with lower performance levels in 14 of the 17 ratios. High managed care penetration appeared to have a positive influence only in the case of days of revenue in accounts receivable, bad debt expense ratio, and average age of plant (Solovy, 1998).

Clearly, the operating characteristics of health plans can

have a negative impact on hospital performance.

There is also the potential, most often cited by anecdote, for managed care plan practices to have adverse effects on patient care. In a survey conducted in Minneapolis, physician providers in three health plans were surveyed on health plan practices that promote or impede the delivery of high quality medical care. The study showed that, from the physician perspective, there were plan practices that had significantly adverse effects on the ability of the physicians to provide quality patient care (Borowsky, Davis, Goertz, and Lurie, 1997).

The same study also showed that there were significant differences in ratings of the plans and that the physician perspective "is clearly distinct from that of plan enrollees" (Borowsky et al., p. 920). The Newsweek article also quotes David Lansky, president of the Foundation for Accountability, in reference to the coming shakeout among managed care plans: "What's scary is that there's no system in place to detect harm to people while the shakeout is occurring" (Spragins, 1996, p. 57). While Lansky may be correct in his assessment, it is also correct that there is no system in place to detect harm to or potential for harm to the most essential element of healthcare, the providers, both hospitals and physicians.

Elizabeth McGlynn (1997) also reported that the perspective of quality is different among and between

patients, providers, and payers and their ratings of quality are likely to be different as well. McGlynn holds that a national quality monitoring system should assess dimensions of care from the perspective of purchasers (payers), patients, and health care professionals (providers). Still, all of these perspectives on ratings of managed care plans tend to focus on clinical measures of quality.

Few examples of efforts to rate managed care plans from the provider perspective were found. Professor Jay Wolfson (1996) for the Hillsborough County (Florida) Medical Association (HCMA) reported one such effort. The study consisted of a survey instrument distributed to the 800 physician members of the HCMA. Of the 19 questions (one was open-ended), only four dealt with primarily nonclinical, business practices of the plans. The MEDSTAT Quality Catalyst rating system, prepared by the MEDSTAT Group of Ann Arbor, Michigan, measures some elements of physician satisfaction with the plans. The areas measured include "paperwork requirements, authorizations for admissions, authorizations for tests and procedures, help with the appeals process for denied claims, and the like" (Andree Joyaux, personal communication, October 17, 1997). The interests of hospitals are not considered at all.

Writing in Hospital Topics, Omachonu and Johnson (1993) clearly stated that "quality in HMOs should be defined in

the context of three key elements:

- The ability of an HMO to meet or exceed the expectations of its customers (enrollees, physicians, employers, third party payers, the community, etc.)
- Its ability to "hang on" to customers (enrollees)
- Its ability to attract and retain qualified physicians." (p. 13)

The inclusion of providers in two of the three key elements is significant.

In a previously published article, this author specifically called for rating of managed care plans by providers on performance indicators that dealt with the business and administrative aspects of the provider-plan relationship (Barber, 1997). Thus, only Omachonu, Johnson, and Barber specifically recognized that the "quality" of the plan from the provider's business perspective should have a bearing on the willingness of a provider to join or continue with a managed care plan.

The Healthcare Association of Southern California reported one of the few examples of attempts to rate health plans from a hospital perspective. In 1999, the association reported the results of its third annual survey of regional hospitals' relationships with 13 area health plans. Its reports from the previous two years were not released. The 1999 report was released "in order to pressure plans to improve performance." (Shinkman, 1999, p. 16)

Statement of the Problem

Among the assertions routinely made by both managed care plans and providers during the contract "mating dance" is their respective interest in working as "partners" in the new relationship. Now, this usually has nothing to do with the legal form of the new relationship. Rather, it describes the working relationship that each wants with the other. Unfortunately, even the best intentions are often undone by the realities of contract terms and operational practices of the managed care plans.

Separate and apart from the items covered by the current plan rating and accreditation studies, factors can be isolated which make a managed care plan more or less favorable as a business partner for healthcare providers. Yet, no broadly-based studies have been conducted and no rating systems have been developed to rate or accredit healthcare plans from the provider perspective. This absence of standards and performance comparisons permits the managed care plans to direct their attention to protecting their image among consumers and employers, with less regard for their effect on those who actually provide the product—healthcare—which they broker.

The fact that managed care plans do discount their relationships with hospitals was demonstrated in a Hospitals & Health Networks survey of hospital executives, physician

executives, and managed care executives. In the survey, the partnership between managed care organizations and hospitals was given the lowest rating of importance by managed care executives ("Strategies & Tactics," 1998). In reference to the generally poor performance ratings given health plans in the surveys of the Healthcare Association of Southern California, Jim Lott, Executive Director, stated "It's hard to do anything but simply say that health plans by and large are not interested in resolving issues with providers." (Shinkman, 1999, p. 16)

This imbalance of external influences on the operations of managed care plans puts providers in general and hospitals in particular at a disadvantage. The same survey of hospital executives, physician executives, and managed care executives showed that all three groups thought that the managed care plans had the advantage in managed care contracting ("Strategies & Tactics," 1998). Little external motivation pushes plans to strive to be seen as "quality business partners" among the providers of healthcare services.

As the influence of managed care plans in healthcare increases, they have and will continue to come under increasing external and internal scrutiny. This scrutiny focuses on measures of perceived "quality" and is almost exclusively oriented toward the interests of consumers and payers. In this process, the interests of the providers of

care to the members of the plans are at best overlooked and at worst compromised. Managed care plan operations driven solely by financial performance expectations and consumer and payer perceptions of "quality" can be detrimental to providers and, in some cases, even detrimental to the health of plan members. It is, therefore, necessary to bring a countervailing influence to the market to cause managed care plans to direct their attention to their "quality" as business partners with those who provide the care to their members.

A national system of rating managed care plans on the basis of factors that are important to providers would allow physicians and hospitals to be more knowledgeable when negotiating with managed care plans with which they are considering contracting. Obviously, a managed care plan with a low rating would be a less desirable partner.

Just as a low rating in any of the other surveys may inhibit a plan's access to members, a low rating as a business partner should inhibit a plan's access to providers, or at least access at terms most favorable to the plan. The possibility of this effect was demonstrated in February 1999, when a 52-physician group practice in Denver withdrew from the Medicare fee-for-service system. The group told its Medicare patients they would have to join one of three Medicare HMOs. The physicians selected HMOs that are "easier to deal with" than the Medicare program with its

new anti-fraud paperwork requirements and cited "the savings in time and hassle." (Hubler, 1999, p. 1)

Visibility of the performance of a plan as a business partner would be the outcome of implementing a system of rating from the provider perspective. That visibility should bring a powerful external influence to both the operations and policies of managed care plans and bring balance to what is, currently, a biased system of "quality" assessment.

Purpose of the Study

The purpose of this study is to begin the process of developing a system to evaluate and rate health plans in their performance as business partners to healthcare providers. Theoretically, all healthcare providers—physicians, hospitals, home care, long-term care and other providers of healthcare services—would have an interest in performance factors that influence their business relationships with health plans. To begin the process, this study will determine the importance of the existing accreditation and rating systems and identify health plan performance factors that are important to acute care general hospitals in evaluating their participation in health plans. It will also identify the relative importance of each factor identified. The factors identified can then become

the basis for development of a system for rating managed care plans as hospital business partners. Similar, future studies can extend the scope to include the interests of physicians and other providers of healthcare.

The Research Question

This study will seek to answer the following questions with respect to health plan participation of hospitals: 1) How important to acute care general hospitals are health plan accreditation and ratings by the major health plan accreditation and rating systems; 2) Are there other health plan operational factors that may be important to acute care general hospitals that are not included in current rating systems; and, 3) Which health plan operational performance factors are most important to acute care general hospitals?

C H A P T E R II

REVIEW OF THE LITERATURE

Overview

As might be expected, there is a rich supply of material on managed care quality and health plan quality. A simple search of the Internet, using the InfoSeek search engine, for the term "healthcare" produced over 4,000,000 "hits." Adding Boolean logic to the search for the terms "healthcare" AND "quality" produced over 2,000 "hits."

Similarly, a search of the National Institutes of Health MedLine database for the term "health plan" produced over 6,600 "hits." Adding Boolean logic to the search for the terms "health plan" AND "quality" produced over 1,100 "hits." Adding the term "ratings" to the searches usually reduced the number of "hits" to more manageable numbers. The challenge, of course, was to locate material that not only included those terms, but also was actually relevant to the scope of the study.

Numerous searches were conducted against not only the Internet, but also against such well-known databases as

MedLine, HealthStar, ABI Inform, and others. Searches were also made against the on-line archives of publications as diverse as The Charlotte Observer, The Wall Street Journal, Managed Care Magazine, Fortune, Hospitals & Health Networks, Business Week, and The Annals of Internal Medicine. Searches were made using a variety of terms and various combinations of the terms. Search terms used included "healthcare," "health plan," "managed care," "quality," "ratings," "evaluation," and "accountability."

All combined, these searches produced literally thousands of references to be evaluated. Many of the references dealt with physicians' perspective of quality of health plans or quality under managed care. These, of course, were mostly out of the scope of this study. However, they do indicate a considerable passion about quality and managed care health plans among physicians and suggest opportunities for further study.

A thorough review of the references identified through all of the searches described above produced the list of references shown for this study. Along with this author's previous work on this subject, all of these references have some relevance to the scope of this study. A thorough review of each of the other references listed for this study revealed that many of the relevant materials regarding health plan quality evaluations or ratings could be

categorized into five categories. The categories used for the work of other authors are: (1) commercial rating systems, (2) regulatory ratings and evaluations, (3) ratings and evaluations in the professional literature, (4) ratings and evaluations in the popular literature, and (5) other surveys and rating efforts. They are discussed and summarized below within those categories.

The remaining references, found in virtually every category of sources, deal with what hospital representatives are writing about health plans and reflect their perspective of quality. The topics that are repeatedly referenced in articles about managed care, health plans, and managed care contracting represent factors that are of importance to hospitals. As such, they are potential factors for rating of health plans from the hospital perspective. These references are discussed in the section on "other potential factors."

Previous Work by the Author

In March 1997, this author's proposition that managed care plans should be rated as business partners was published in Healthcare Financial Management. This paper proposed that health plans should be rated on fifteen factors based on the author's experience in healthcare

management (Barber 1997). The paper was based on an earlier, unpublished manuscript by this author. The list of factors proposed for rating is shown in Table 1. A discussion of the significance of the factors, from the unpublished manuscript also follows.

Medical Loss Ratio

An HMO's medical loss ratio is a measure of the proportion of its premium revenue that has been used to provide medical care to its members. Medical loss ratios typically fall in the 75 percent to 98 percent range (Weiss Ratings', 1998). Some strongly managed plans have been known to post lower medical loss ratios and plans in highly competitive markets often post higher medical loss ratios. For 1997, the average HMO among those rated by Weiss Ratings, Inc., had a medical loss ratio of 90.1 percent (Weiss Ratings', 1998). A high medical loss ratio indicates relatively smaller shares of premium revenue being consumed by other than provision of medical care. A low medical loss ratio indicates that high sales and administrative costs, high profits, or both high sales and administrative costs and high profits consume a larger share of the premium dollar. If the June 24, 1996, issue of Newsweek is correct that the HMOs seek to "wring more costs out of doctors and

hospitals" (Spragins, 1996, p. 57), a low medical loss ratio suggests that any inefficient use of premium dollars may be at the expense of providers.

Compensation Cost/Benefit

One of the typical benefits that is offered to providers by legitimate managed care plans is the direction of increased volume (steerage) in exchange for more favorable rates (discounts). The compensation cost/benefit factor would measure the relationship of compensation to steerage or the ability of the plan to deliver the promised increase in volume of business.

Prompt Payment Factor

Another benefit typically promoted to providers is more prompt payment than in standard indemnity plans. The improved cash flow is supposed to compensate for the discount that is given. Some plans are more conscientious about honoring the contractual discount than about honoring the contractual prompt payment terms. Very few providers or plans monitor promptness of payment, even though failure to achieve the promised prompt payment obviates one of the promised benefits to the provider. The prompt payment

factor would measure the plan's ability to deliver the prompt payment benefit.

Authorization Promptness

Most legitimate managed care plans have some type of authorization or certification requirement for hospital admissions, surgeries, and certain high-cost procedures or drugs. This imposes an administrative process which can delay treatment and cause frustration among providers. Promptness in responding to provider requests for required authorizations would be a measure of the plan's efficiency in operating its authorizations and certifications programs.

Authorization Convenience

Perhaps no other aspect of managed care utilization management programs causes more provider frustration than authorization and certification requirements. Systems requiring maintenance of supplies of forms and processing paper requests add unnecessary delays and administrative costs. Telephonic systems, either automated or attended, are improvements, but only if they do not result in interminable periods on "hold" and if they are attended by well-trained and professionally qualified personnel. Fully

electronic systems are better than all others except for those plans that rely on highly trained and professional providers to make appropriate decisions regarding the care of their patients. An authorization convenience factor would measure the "provider friendliness" of the plan's utilization management systems.

Insurance Verification Promptness

Although many managed care plans contractually require providers to verify a patient's insurance coverage, most providers recognize the need to verify insurance coverage in order to clearly identify who will be paying the bill. Systems which are unable to promptly (not to mention accurately) verify a member's coverage add delays and administrative cost. An insurance verification promptness factor would measure the efficiency of the plan's system.

Insurance Verification Convenience

Telephonic systems for insurance verification are also satisfactory, again subject to prompt service by well-trained and professionally qualified personnel. Again, fully electronic systems are best. An insurance verification convenience factor would measure the "provider

friendliness" of the plan's verification systems.

Payment Accuracy

One of the most egregious shortcomings of which a managed care plan can be guilty is inability to accurately adjudicate and pay claims according to its members' benefit plans and according to the terms of its provider contracts. Inaccurate claims payments cause delays in settling patient accounts and enormous increases in administrative costs associated with reconciling payments, identifying the errors, and rebilling claims. However, the most egregious aspect of this shortcoming is the frustration caused the plans' members and the patient relations problems caused for the providers. A payment accuracy factor would measure the plan's ability to accurately honor its administrative obligations.

Medical Management Intrusiveness

Managed care plan medical management operations exist along a continuum of intrusiveness into the operations of the contracting providers. The better plans, as business partners, are minimally intrusive, perhaps even helpful in managing the care of members. At the other extreme, are the

plans that providers would characterize as intolerably intrusive, meddlesome, and perhaps incompetent. The great majority of plans perform the inherently intrusive function of medical management in ways that are perhaps annoying but tolerable and acceptable. A medical management intrusiveness factor would measure the performance and behavior of the plan's medical management functions in terms of intrusiveness into the provider's operations.

Provider Relations Efficiency

Most plans have a provider relations function to interface with providers in areas of plan operations. Assistance is often needed in procedural matters, credentialing, medical management issues, and claims matters. The better plans have highly responsive, well-trained, and very helpful provider relations personnel. Plans which are less desirable as business partners may, on the other hand, have provider relations personnel who are intolerably unresponsive and may even be obstacles to efficient operations. While most plans fall somewhere between these two extremes, a provider relations efficiency factor would measure a plan's performance in the area of provider relations.

Member Education Effectiveness

Most Americans simply do not understand their health benefits plans. They do not understand the limitations of their benefits, and they do not understand the requirements imposed on them to obtain full coverage. The more complex the plan and the more stringent the utilization controls, the less likely it is that the members will understand their plan's requirements. When members, who have not been adequately educated as to the limitations and requirements of their plan, find that their coverage has been reduced for using the wrong provider or failing to follow the requirements of the plan, they often direct their anger and frustration at the provider. The providers often find themselves having to explain the mechanics of an irate member's plan and suffer from damaged patient relations due to the failure of the plan to adequately educate its members. Member education is clearly a plan responsibility, and plans should be evaluated on the degree to which their members understand the plan. A member education effectiveness factor would measure the degree to which the plan's member education program produces members who understand their benefits and the procedures required of them.

Recorded Complaints

Most of the states monitor the number of complaints filed against regulated managed care plans. The ratio of recorded complaints per thousand members can provide some insight as to the patient relations problems that may be expected from participation in a particular plan. A recorded complaints factor would measure a plans effectiveness in its operations and member relations.

Risk Transfer

The way in which a plan compensates a provider can result in significant transfer of the insurance risk, for which the plan is licensed and collects premiums, to the provider. Discounted charges result in the least transfer of risk to the provider, while per diems and fee schedules transfer greater degrees of risk. Case rates and the various forms of capitation result in the greatest degree of transfer of risk to providers. A risk transfer factor would measure the degree to which the plan seeks to shift its risk to the provider.

Contract Terms

Managed care plan provider contracts have numerous terms, other than compensation rates, which can be either favorable to providers or unfavorable to providers. These would include provisions regarding billing of members, coordination of benefits, and "gag" clauses, among many others. A contract terms factor would measure the degree to which the non-financial terms of provider contracts are favorable or unfavorable to providers.

Contracting Equity

Provider participation agreements for most managed care plans are sometimes badly unbalanced, in terms of the relative rights and responsibilities of the provider and the plan. The worst contracts have long lists of provider responsibilities and long lists of causes for which the plan may terminate the contract, with scarcely a mention of plan responsibilities and no cause for which the provider may terminate the contract. The worst contracts permit only the plan to publicize the provider's participation and provide that the plan may unilaterally amend the contract, including the agreed upon rates. Naturally, a contract in which such terms are balanced in application to the parties and which

may only be amended by the mutual consent of the parties originally agreeing to the terms is more appropriate. Accordingly, plans' contractual terms should be evaluated on the degree of mutuality of the following terms of the participation agreement:

* Maintenance of licenses and permits
* Maintenance of accreditation
* Maintenance of insurance coverage
* Reporting of insured events
* Assignment of rights and responsibilities
* Publicizing relationship
* Cause for termination
* Amendments
* Indemnification

Table 1

Business Partner Rating Factors from Barber

Medical loss ratio
Compensation cost/benefit
Payment promptness
Authorization convenience
Authorization promptness
Insurance verification convenience
Insurance verification promptness
Payment accuracy
Medical management
Provider relations responsiveness
Member education effectiveness
Recorded complaints
Risk transfer
Contract terms
Contract equity

Source: (Barber, 1997)

The Commercial Rating Systems

A number of formal, commercial rating systems are in operation and provide ratings on managed care plans. As noted in Chapter 1, the commercial rating systems focus almost exclusively on factors that are of primary interest to payers and consumers. The principal rating systems include the HMO ratings of The National Committee for Quality Assurance (NCQA) and the preferred provider organization and HMO ratings of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). These organizations are primarily industry groups. They conduct accreditation surveys and produce health plan quality reports on a voluntary basis. The cost of the accreditation and ratings process are covered by fees assessed on organizations seeking accreditation and by sales of the accumulated quality data and reports.

A second category of commercial rating systems includes those of the A. M. Best Company and Weiss Ratings, Inc. These systems generally gather data on operational and financial performance from reports filed with regulatory agencies. The data is analyzed and reported in rating schemes similar to those used in the securities business for stocks and bonds. The cost of the Best rating process is covered partially by fees paid by the rated companies and

partially by the sale of ratings reports. The cost of the Weiss ratings is covered by the sale of ratings reports and subscriptions.

CareData Reports and The MEDSTAT Group's Quality Catalyst program represent a final category of commercial rating systems. The CareData Reports are based on a survey of members in a number of large managed care markets. The MEDSTAT rating system is based both on reported operational and financial performance and on data obtained from surveys. The fact that MEDSTAT surveys physicians makes it the only commercial system to consider the perspective of the provider. Fees charged to the rated organizations and the sale of rating reports cover the cost of the rating process.

Each of the major commercial rating systems is discussed in detail below.

The National Committee for Quality Assurance

The National Committee for Quality Assurance (NCQA) is a nonprofit organization based in Washington, D.C. Formed by an HMO trade group in 1979, it has been independent since 1990 and has established itself as the leading source of accreditation of HMOs. Since beginning its accreditation programs in 1991, NCQA has accredited about 300 health plans (Jeffrey, 1998).

NCQA measures 50 quality standards for health plans ("What is MCO," 1999). The 50 measures are included in one of six categories: 1) quality improvement results, 2) physician credentials and performance, 3) member rights and responsibilities, 4) preventive health services, 5) utilization management process and appeals process, and 6) medical records (Managed care organization, 1998).

The results of NCQA's annual evaluation of health plans are reported in the annual Quality Compass report. The Quality Compass reports are based on measurements from the Health Plan Employers' Data and Information Set (HEDIS) (The state of, 1998), a set of measurements developed by some of the nation's largest employers for evaluating their health benefit plans. Thus, the measures and evaluations are clearly oriented to the interests of payers of health plan premiums.

The HEDIS data set and measures are heavily oriented to clinical performance measures. Of the 54 elements of the data reporting set for 1999 ("HEDIS 1999 reporting," 1998), 45 are measures of clinical performance or results. The remaining nine measures deal with member satisfaction, plan stability, and cost of care. Selected examples of the clinical measurements in the HEDIS data set are shown in Table 2.

The NCQA rating and accreditation process is the object

of some criticism. Critics of the NCQA ratings and the HEDIS data set point out many plans do not participate and not all "required" data are consistently submitted (Greene, 1998). According to a William Mercer, a benefits consulting firm, only about half of the nation's 650 HMOs participate in the NCQA accreditation and reporting process (Anderson, 1999). The Health Care Financing Administration (HCFA), which requires that the HEDIS data set be reported for Medicare HMOs, found serious problems with reliability. HCFA attributed these problems to plan information systems and to ambiguity in the HEDIS measurement specifications (Greene, 1998).

Critics also point out that the publicly reported results are skewed in favor of plans that are performing well. That is because the plans can decline to have their scores and results reported publicly. In 1997, 115 of the 450 reporting plans refused to allow public release of their scores ("Zeroing in on," 1998). Critics and participating plans alike also note the fact that the data are all self-reported, and audit has not been required (Greene, 1998). NCQA plans to require audited data for 1999.

Perhaps the most telling criticism of NCQA's HEDIS-based reporting is that very few employers insist on accreditation for their employee health plans. Despite the fact that the HEDIS data set is ostensibly oriented to the

needs of employers, according to a study of 2,600 employers by KPMG Peat Marwick, only nine percent of the employers required accreditation and only six percent even used the HEDIS data (Scott, 1998).

The HEDIS reporting requirements also include eight elements of descriptive information about the plan. Some of the plan descriptive information and some of the nine non-clinical measures may be useful to hospitals and other providers. These measures are shown on Table 3.

Some of these nonclinical factors measured in the HEDIS data set may be useful to hospitals and other providers in evaluting health plans as business partners.

The Joint Committee on the Accreditation of Healthcare Organizations

The Joint Committee on the Accreditation of Healthcare Organizations (JCAHO) is best known for its accreditation of hospitals, home health agencies, lab services and other healthcare providers. The JCAHO, based in Oakbrook Terrace, IL, conducts some 18,000 evaluations per year (Lawrence, 1998). In recent years, the JCAHO has expanded its accreditation programs to include networks, health plans, and preferred provider organizations. JCAHO has accredited approximately 50 health plans (Jeffrey, 1998).

Since many health plans already report under NCQA's HEDIS measurement system, the JCAHO has allowed health plans seeking accreditation from JCAHO to select 10 measurements from one or more of the existing measurement systems. Plans may use JCAHO measures, HEDIS measures, or those from the Foundation for Accountability, University of Colorado Health Science Center, or the University of Wisconsin (Lawrence, 1998).

The JCAHO measures primarily apply to acute care hospitals. The University of Colorado Health Sciences Center measures primarily apply to home care services. The University of Wisconsin measures primarily apply to long-term care services. The NCQA measures are based on the HEDIS data set. The Foundation for Accountability (FACCT) measurements apply to networks and health plans. The FACCT measures include 35 measures, most of which are clinically or health status oriented. Thirteen of the 35 measures deal with member satisfaction with various elements of plan performance. None of the measures address administrative factors in plan performance. Examples of the HEDIS measures are listed above. Selected rating factors from the Foundation for Accountability are listed in Table 4.

Because none of the JCAHO measurement options address operational factors of interest to hospitals contracting with health plans, the JCAHO accreditation process does not

address the interest of hospitals in evaluating health plans as business partners.

A. M. Best Ratings

The A. M. Best Company publishes Best's Ratings of firms in the insurance industry. With offices in Oldwick, NJ and London, England, the company has been providing evaluations of the financial condition of insurance companies since 1899 ("A. M. Best Co.," 1998). Best uses a rating scheme similar to those used for ratings of financial instruments. Ratings range from A++ to D, with additional ratings for companies in regulatory or financial difficulties. The company also assigns a rating from 9 (highest) to 1 (lowest) of the rated company's financial performance. According to the company, "the Best's Rating represents an opinion on a comprehensive quantitative and qualitative evaluation of a company's financial strength, operating performance and market profile" ("A. M. Best Co.").

Best's Ratings are fundamentally financial ratings of the companies rated. The source of information for the ratings is primarily data reported to the insurance commissioners of each state, the companies' audited financial statements, and other filings with state and federal regulatory agencies. The company also obtains

certain data directly from the subject companies (A. M. Best Co.," 1998).

According to the company, over 100 key financial tests and supporting data are analyzed in developing a company rating. The rated company's results are compared with standards for peer companies. The analysis is conducted in three key performance areas: leverage/capitalization, profitability, and liquidity ("A. M. Best Co.," 1998). In considering a company's leverage, Best measures operating leverage, financial leverage, and asset leverage. Capital structure, reinsurance programs, and loss reserves are also measured. Some specific factors measured by the A. M. Best system are shown in Table 5.

From the standpoint of evaluation or rating of health plans, Best's Ratings have two shortcomings. First, the companies rated are insurance companies. They are rated on a corporate basis. Most health plans are not insurance companies in themselves, but are product lines or subsidiaries of insurance companies. Furthermore, a common organizational structure has health plans locally incorporated and operated on a local or regional basis. A national health plan may have dozens of separately incorporated and separately operated subsidiary plans around the country. Those subsidiary plans may have strongly differing financial and operational characteristics compared

to the plan as a whole or compared to the parent company. An individual subsidiary or an individual plan may not be the subject of a Best rating report. Thus, Best's Ratings may be of little value in evaluating a local health plan by consumers, payers, or hospitals.

Secondly, the ratings are fundamentally ratings of the financial performance, soundness, and viability of the rated companies as members of the insurance industry. The ratings do not directly rate the operating characteristics of any subsidiary health plans. Thus, while a hospital may be interested in the underlying financial strength of the parent company of a local health plan, the Best's Ratings are likely to be of little value to a local hospital in evaluating participation in a particular local health plan.

Weiss Ratings

Weiss Ratings, Inc., located in Palm Beach Gardens, FL, has been publishing independent ratings of HMOs and health insurers for over 20 years. Weiss Ratings, although also primarily financial evaluations and ratings of the health plans, are more consumer-oriented than the Best Ratings. According to the Fall 1998 Weiss Ratings, the ratings are intended to help consumers, employers, and consultants select health insurance plans and are "specifically designed

to inform risk-averse consumers about the financial strength of HMOs and other health insurers" (Weiss Ratings' Guide, 1998).

Like its competitor, the Weiss ratings are based primarily on reports filed with state and federal regulatory agencies. Weiss also obtains some supplemental information directly from the rated companies. The rating scheme is also based on a scale from A+ to F like those found in ratings of financial instruments. The ratings are the result of "a complex analysis of hundreds of factors that are synthesized into several indexes, depending on the type of company" (Weiss Ratings' Guide, 1998). Some of the factors considered in the Weiss Ratings are shown in Table 6.

A strength of the Weiss Ratings is the breadth of the industry covered by the ratings. According to the U. S. General Accounting Office, Weiss rated 1,449 health plans and insurers, or over 70 percent of the universe (Weiss Ratings' Guide, 1998). According to Weiss, their analysis included all Blue Cross/Blue Shield plans and over 500 HMOs. Rated plans include medical reimbursement insurance (indemnity), managed health care plans (HMOs and PPOs), disability income plans, long-term care plans, and dental insurance plans.

Weiss rates health plans as individually licensed

products, regardless of corporate ownership, and they pointedly note that each company or plan rating stands on its own—"affiliated companies do not automatically receive the same rating" (Weiss Ratings' Guide, 1998). The fact that the ratings cover individual local plans makes them more valuable to local consumers, employers and hospitals. However, the ratings do not directly rate the operating characteristics of the plans and thus only cover a limited portion of the information of interest to hospitals. Beyond the interest in the underlying financial strength of a plan, the ratings provide little information for the hospital in evaluating participation in a particular local plan.

CareData Reports

CareData Reports, Inc., of White Plains, New York publishes CareData Reports. CareData was founded in 1993 and is a wholly-owned subsidiary of Medirisk, Inc. The company specializes in providing information about consumer satisfaction with managed health care. The company's clients are typically employers or managed care organizations that are interested in how well consumers' needs are being met by managed care plans ("Welcome to," 1999)

The CareData surveys are conducted in 26 large managed

care markets across the United States. The surveys are conducted biennially and are employer-based. Since 1993, the company's surveys have included the employees of more than 380 employers enrolled in more than 200 commercial HMOs, point-of-service plans, open access plans, and Medicare Risk HMOs. ("Welcome to," 1999)

The company states that it is "dedicated to assessing employees' satisfaction with managed care health plans" and is "committed to providing purchasers of health care with useful and actionable information…" ("Welcome to," 1999, p. 1). Thus, its focus is clearly on the interest of consumers and payers.

The reports are published on a regional basis and cover more than 150 topics relative to member satisfaction. Among the areas reported are:

- Reasons why consumers chose health plans
- Analyses and comparisons of health plans
- Plan-by-plan performance review
- Key drivers of satisfaction, recommendation and retention
- Disease management
- Disease prevention ("Welcome to," 1999, p. 1)

The topics covered in the survey are broadly grouped into the following groupings: medical providers, medical issues, pharmacy benefit, customer service/administration,

plan design, selection, retention, recommendation, general experience, and demographics (of respondent) ("Welcome to," 1999). Specific topics that may be of interest to providers are listed in Table 7.

Clearly the CareData Reports focus on the perspective of the health plan member and the payer. The surveys address issues relevant to providers, but the focus is on evaluation of the members' interaction with the providers.

MEDSTAT Quality Catalyst

The MEDSTAT Quality Catalyst is the newest of the commercial rating systems. Based on a surveying methodology conducted in 1997, the first report was released in September 1997. The program is a new entry into health plan quality measurement. It is produced by an alliance of The MEDSTAT Group, of Ann Arbor, MI, J. D. Power and Associates, the Southern California consumer research firm best know for its automobile owner satisfaction surveys, and the Boston-based New England Medical Center ("Metro markets," 1997).

The goal of the Quality Catalyst program is to "provide comparative information on quality of different types of health plans without relying on plans' self-reported data, which can be perceived as biased" (Mullen, 1997). To achieve that goal, the Quality Catalyst alliance developed a

series of questionnaires for employer benefit managers, health plan enrollees, and physicians in six metropolitan markets. The markets surveyed were Atlanta, New York, Memphis, San Francisco, Detroit, and Lansing, MI ("Metro markets," 1997).

The Quality Catalyst alliance perceives that there is a void in unbiased, balanced, comparative data about competing types of health plans ("Metro markets," 1997). Their surveys also include all types of health plans—HMOs, PPOs, point-of-service plans, and indemnity plans—in the markets surveyed. According to MEDSTAT, 39 health plans were surveyed with slightly more than half being HMOs (Mullen, 1997).

The surveys are unique in the inclusion of enrollees, employers, and physicians. Marketing materials for the Quality Catalyst refer to the "three key stakeholders who see the issue of quality from different perspectives." The perspective of the enrollee includes "satisfaction with the plan and satisfaction with care" while the perspective of the employer includes "satisfaction with cost and ease of working with particular plans in areas such as customer service, claims processing, plan accountability, and overall value received." The perspective of the physician is said to include satisfaction with "issues ranging from job and practice satisfaction and their impact on quality to

satisfaction with plan policies and procedures." In this unique attention to the perspective of the physician, the marketing materials claim that the Quality Catalyst responds to health plan needs to "recruit and retain the best physicians by responding to what physicians say is important to them" (The MEDSTAT Quality Catalyst: the leader, 1997, p. 3). Dennis Becker, of MEDSTAT, adds that the surveys "will give physicians a new way to express their concerns about individual health plans" (Mullen, 1997).

Because of the proprietary nature of the product, complete information on the factors measured by The Quality Catalyst was not available. In a letter from MEDSTAT, the measurement of the physician perspective on the rated health plans was to include:

> Administrative aspects of the health plan, such as paperwork requirements, authorizations for hospital admissions, authorizations for tests and procedures, help with the appeals process for denied claims, and the like. We also measure the physicians' satisfaction with the plan, physicians' satisfaction with the care they are able to give, physicians' intent to recommend the plan to others, physicians' ratings of plan restrictions on care such as limits on tests or procedures, hopital admissions, etc., and the impact of these limits on the physicians' ability to deliver quality care. (A. Joyaux, personal communication, October 17,1997)

Review of the company-provided description of the Quality Catalyst report also provides insight to the factors measured. The program claims to measure "the three critical dimensions: satisfaction, processes of care, and outcomes of

care" (The MEDSTAT Quality Catalyst Report:, 1997, p. 1)." Perusal of the report description reveals some of the rated factors as indicated in Table 8.

Certainly the Quality Catalyst represents a unique entry in health plan quality measurement. Indeed, its inclusion of the perspective of the physicians in its measurements is a strength. However, the plan falls short of its claim to be "the first to provide a whole-system perspective on health plan quality" ("Metro markets," 1997, p. 2). Conspicuously absent is any consideration of the perspective of hospitals as providers of care and stakeholders in the measurement of health plan quality.

Table 2

Selected HEDIS 1999 Clinical Measures

Childhood immunization status
Adolescent immunization status
Advising smokers to quit
Breast cancer screening
Cervical cancer screening
Beta-blocker treatment after heart attack
Eye exams for diabetic patients
Antidepressant medication management
Availability of primary care providers
Member satisfaction with services
Well-child visits in first 15 months
Inpatient utilization
Cesarean section rate
Outpatient drug utilization

Source: NCQA ("HEDIS 1999," 1998)

Table 3

Selected HEDIS 1999 Nonclinical Measures

Disenrollment rate
Practitioner turnover
Years in business
Total membership (covered lives)
Indicators of financial stability
Rate trends
High-Occurrence/High-cost DRGs
Physician board certification rates
Enrollment by payer

Source: NCQA ("HEDIS 1999," 1998)

Table 4

Selected Foundation for Accountability Factors

Breast Cancer Testing
Conservative breast surgery
Breast cancer services
Major depressive disorder providers
Coping with major depressive disorder
Foot exams for diabetic patients
Blood sugar tests for diabetic patients
Eye exams for diabetic patients
Diabetic patients' hospital days
Helping smokers quit
Member satisfaction with services
Member satisfaction with providers
Member satisfaction with choice of providers
Members will recommend plan to others
Member overall satisfaction

Source: JCAHO("Indicator list," 1999)

Table 5

Selected A. M. Best Rating Factors

Financial leverage
Operating leverage
Asset leverage
Spread of risk
Reinsurance program
Quality of assets
Diversification of assets
Loss reserves
Interest rate risk
Credit risk
Capital structure
Cash flow
Debt service coverage
Cash and near cash balances
Net income
Investment Income
Revenue composition
Quality of management
Industry sector
Lines of business
Market risk
Competitive market position

Table 5 (cont.)

Spread of risk
Event risk

Source: A. M. Best ("A. M. Best Co.," 1998)

Table 6

Selected Weiss Rating Factors

Total assets
Capital
Risk-adjusted capital
Number of member physicians
Enrollment
Principal investments
Investments in affiliates
Group affiliation
Net premiums
Net income
Liquidity
Loss reserves
Medical loss ratio
Administrative loss ratio
Complaints (Medicare)
Reconsiderations (Medicare)
Insurance risk
Reinsurance
Interest rate risk

Source: Weiss Ratings' Guide (1998)

Table 7

Selected CareData Reports Rating Factors

Satisfaction with PCP
Choice of PCP
Getting appointment with PCP
Staff knowledge of plan payments
Knowledge of referral policies
Types of specialists visited
Satisfaction with specialists
Choice of specialists
Referrals to specialist
Hospital quality and reputation
Utilization of hospitals
Disease management
Childhood vaccinations
Mammograms
Pap smears
Flu shots
Glaucoma testing
Prostrate screening
Smoking counseling
Satisfaction with pharmacy plan
Prescription compliance
Satisfaction with customer service

Table 7 (cont.)

Coordination of benefits
Appropriateness of billing
Paperwork required
Ability to contact plan
Reasons for selecting plan
Intention to re-enroll
Intention to recommend plan
Overall satisfaction
Satisfaction with medical care
Satisfaction with premium
Handling of out-of-network claims

Source: CareData Reports ("Welcome to," 1999)

Table 8

Selected Quality Catalyst Rating Factors

Paperwork requirements
Authorizations required
Appeals process
Physician satisfaction with plan
Physician satisfaction with care
Physician intent to recommend
Plan restrictions on care
Physician morale
Physician job stress
Physician compensation method
Customer service
Account services
Plan decision making style
Choice of providers
Access to care
Waiting time
Flu shots
Interpersonal care
Mammogram
Pap smear
Plan improvements
Smoking counseling

Table 8 (cont.)

Thoroughness of care
Time pressures
Enrollee recommendations
Intent to stay with plan
Ease of referrals
Access to physicians by phone

Source: MEDSTAT (The Quality Catalyst Report, 1997)

Regulatory Ratings and Evaluations

There are more than 60 million persons enrolled in HMOs in the United States. There are another 90 million-plus persons in PPOs. These numbers, the erosion of the authority of healthcare professionals to ensure quality care, and the role of government as a major purchaser of healthcare, puts health plan quality assurance clearly in the public policy arena (Wilensky, 1997). The states pay a major portion of the cost of Medicaid programs and pay more than half of the nation's long-term care bill (Riley, 1997). This, plus the fact that state governments are looked to by the population for protection of the consumers, puts health plan quality squarely on the states' policy agenda.

The focus of the federal government has traditionally been on Medicare quality issues. By law, the regulation and quality monitoring of commercial health plans is a responsibility of the states (Wilensky, 1997). The federal government regulates HMOs who enroll Medicare beneficiaries. It also oversees the states in their regulation of HMOs that enroll Medicaid beneficiaries. All of the states regulate HMOs. Seventeen of the states regulate PPOs, 15 regulate physician-hospital organizations (PHOs), and 12 states regulate independent practice associations (IPAs) (1998 national survey, 1998).

The federal government and about 40 of the states require some type of quality review and reporting. Thirty of the states conduct their own quality reviews, while about 10 accept reviews by outside agencies such as NCQA or JCAHO. About 40 percent of the states require the submission of HEDIS data. (1998 national survey, 1998) Additionally, some of the states provide summaries or surveys regarding health plan quality for the use of the public.

The federal government uses the HEDIS data set and has also been active in developing numerous rating instruments, survey instruments, and evaluation guides for use in evaluating and selecting health plans. The various systems and methodologies used in the regulatory arena are discussed below.

Federal Government Activities

The federal government has a number of programs for evaluating and rating health plans and continues to develop new programs. The most recently announced program was proposed in the August 12, 1998, issue of the Federal Register. In this announcement, the Health Care Financing Administration (HCFA) proposes a "Health Plan Management System" to provide information to aide Medicare beneficiaries in selecting a health plan. The proposed

system will be based in part on the HEDIS data set (Managed Care Report, 1998).

In 1995, the Agency for Health Care Policy and Research (AHCPR) awarded grants to three cooperative groups at Harvard, Research Triangle Institute, and the RAND Corporation. The grants funded the development of "an integrated set of carefully tested and standardized survey questionnaires...to collect and report meaningful and reliable information from plan enrollees about their experiences." The study, known as the Consumer Assessments of Health Plans Study (CAHPS), developed survey instruments intended for use across a broad spectrum of health plans. ("Overview of consumer," 1998).

In its role as a member of the Harvard consortia, NCQA participated in the development of the CAHPS questionnaires. Subsequently, the CAHPS instruments and the NCQA Member Satisfaction Survey instruments were merged and will be required for NCQA accreditation in 1999 ("Overview of consumer," 1998). Selected factors from the CAHPS questionnaires are shown on Table 9.

The 46 items in the CAHPS core questionnaire clearly support the assessment by Scanlon, Chernew, Sheffler, and Fendrick (1998) that the CAHPS "focuses exclusively on health plan quality from the consumer's perspective."

One of the largest efforts to measure health plan

quality is AHCPR's COmputerized Needs-Oriented QUality Measurement Evaluation SysTem (CONQUEST). The effort is large in terms of the number of items measured. Through CONQUEST, quality is measured through a combination of provider characteristics and procedural outcomes included in the 1,185 clinical performance measures included in the database ("CONQUEST Fact Sheet," 1997). Since the measurement factors are exclusively clinical, they are not likely to have any value to hospitals or other providers in evaluating a business relationship with a health plan.

A similar database, also available through AHCPR, is the database of quality indicators from the Healthcare Cost and Utilization Project (HCUP). The HCUP database includes 33 quality indicators. The HCUP QI database focuses on hospital discharge data and is intended for use by hospitals, hospital systems, managed care organizations, business-health coalitions, and state organizations for assessments using hospital discharge data ("Quality indicators," 1998).

Finally, AHCPR has produced a very thorough booklet to assist consumers in choosing health care ("Choosing health care," 1998). The guide is very consumer-oriented, but is decidedly non-clinical. Its seven questions lead a consumer through seven mostly practical considerations in choosing a health plan. Topics of the questions include: 1) member

ratings of the plan, 2) preventive and curative care, 3) plan accreditation, 4) physician and hospital access, 5) plan benefits, 6) convenient access times and locations, and 7) cost of the plan. While not likely to be of much use to providers, the booklet will probably be very useful to consumers facing the selection of a health plan. Unfortunately, only a small percentage of health plans are actually selected by the consumer. Employers or other institutions select most plans on behalf of their employees or members.

State Government Activities

As previously mentioned, most of the states conduct their own quality review. However, in that the respective department of insurance in the states are the agencies responsible for regulation of health plans, the emphasis of the states' quality review is most heavily weighted to finances. The states are least likely to quality in terms of utilization, outcomes, or medical records (Riley, 1997). For example, the North Carolina Department of Insurance Managed Care Division produces an annual report on HMOs in North Carolina. The 49-page report for 1998 includes numerous data on HMOs, including plan profiles, HEDIS reporting, enrollment statistics, utilization statistics,

utilization statistics, complaints statistics, and results of utilization review appeals. Selected measures from the North Carolina DOI report are shown on Table 10.

Several of the state departments of insurance do have consumer-oriented information available to assist consumers in selecting health plans. For example, the Idaho Department of Insurance offers a checklist of questions to ask before joining an HMO.

Table 9

Selected Factors from the Consumer Assessments of Health Plans

Problems finding doctor
Problems getting referral
Problems getting necessary care
Waiting time in office
Time spent with doctor
Rating of personal doctor
Rating of specialist
Rating of health plan
Times visited ER
Times visited doctor's office
Doctor's staff
Plan customer service problems
Plan paperwork problems
Rating of overall health status

Source: CAHPS (1998)

Table 10

Selected NC DOI Reporting Factors

Ownership profile
Product offerings
Premium categories
Enrollment trends
Enrollment by MSA
Market share
Age/gender distribution
Financial Summary
Complaints
HMO service areas
Enrollment by county
Primary care physicians
Specialty physicians

Source: NCDOI (Nelson, Cohen, and Byers, 1998)

Rating Systems in the Professional Literature

Most of the rating systems discussed in the professional literature dealt with evaluation of health plans from the physician perspective or the employee perspective, dealt with health plan "report card" efforts, or approached evaluation of health plans from the consumer needs or consumer guide perspective. There were no studies reported on health plan quality from the hospital perspective, although the Barber article previously cited did call for a national rating system and even specified a number of factors to be considered (Barber, 1997).

The Physician Perspective on Quality

Borowsky, Davis, Goertz, and Lurie (1997) conducted one of the better studies of the physicians' perspective on the quality of healthcare plans. Reported in the Journal of the American Medical Association, the study recognized the importance of the physician perspective and lamented its infrequent use. The authors also noted that other methods of assessing health plan quality overlook the perspective of "health professionals who deliver care" and most frequently include those health professionals as subjects of evaluation.

It would not be much of a stretch to conclude that these statements are also true of the non-M.D. health professionals who deliver care in hospitals or other venues. Indeed, even though the study consisted of a survey of physicians, some of the factors included in the survey questions are potentially of equal interest to hospitals and other providers.

The study consisted of a survey administered to 296 participating physicians in three large health plans in Minnesota. The focus of the questions was on factors that "promote or impede the delivery of high quality care." The factors examined were those identified in focus groups of physicians, interviews with opinion leaders, and literature reviews (Borowsky et al., 1997). Most hospital and other provider personnel would also be interested in factors that bear on their ability to deliver high quality care to their patients. A sample of the factors rated by the physician respondents is shown in Table 11 below.

It is instructive to note that the Borowsky study found substantial differences in the ratings of the three plans. The authors make a good case for the value of the physicians' perspective of health plan quality. They believe that physicians' ratings could be useful in four ways. First, they could be useful to consumers and purchasers of healthcare. Second, they could be useful in

discussions between physicians and the plans about plan quality. Third, they could be useful to plan quality improvement programs. Finally, they and could be useful in establishing relationships between physicians and plans in new markets (Borowsky et al.). The perspective of hospitals and other providers could serve similar useful purposes.

Employee Surveys

Employee satisfaction surveys are a staple in the realm of ratings of health plans. Surveys are conducted by employers, unions, and benefit consultants. One series of studies was conducted for the employers Xerox, GTE, and Digital Equipment Corporation. The surveys, known as the Employee Health Care Value Surveys (EHCVS), were conducted in 1993 and 1995 and were reported in Health Affairs in 1994 by Allen, Darling, McNeil, and Bastien and in 1997 by Allen and Rogers.

The EHCVS surveys were clearly the largest surveys found reported in the literature. Over 14,000 employees were surveyed in the 1993 survey and over 18,000 in 1995 with response rates exceeding fifty percent in both years. The national surveys covered over thirty health plans in which the employees were enrolled. The survey instruments had between 116 and 154 items. (Allen and Rogers, 1997).

Selected factors rated in the EHCVS surveys are shown in Table 12.

Tumlinson, Bottigheimer, Mahoney, Stone, and Hendricks (1997), in Health Affairs, reported another employee survey. The reported survey was conducted in 1994 of Massachusetts state employees by the Massachusetts Group Insurance Commission. Over 3,000 surveys were completed. The survey asked employees to rate the importance of thirteen items relating to plan quality or operations (Tumlinson, et al.). The thirteen factors rated in the Massachusetts Group Insurance Commission survey are shown in Table 13.

Health Plan Report Cards

The development of health plan "report cards" has been a very popular activity. While there have been many report cards developed and published in the popular literature, most of the references to report cards in the professional literature have been reviews or evaluations of the report cards. A case in point is the two articles by Paul L. Grimaldi published in Nursing Management in October 1996 and in May 1997. These two articles primarily review the report cards produced by NCQA, based on HEDIS data submissions. Likewise, Spoeri and Ullman reported on NCQA's 1994 Report Card Pilot Project in their 1997 article in the

Annals of Internal Medicine. Finally, Chernew and Scanlon (1998) performed an extensive analysis of the relationship between health plan ratings in report cards and employee choice of health plans. The focus of their study was the employees of a Fortune 100 company. The data used were from the plan performance reports required by the employer using the HEDIS measurements. Since these efforts merely reviewed ratings utilizing the HEDIS measures, no new factors are identified.

Consumer Guides

In the genre of consumer guides, The Illinois State Medical society produces an annual "HMO Guide." The guide is intended for the use of consumers and purchasers of health plans. The guide provides information on a number of factors that the society believes should be considered in selecting an HMO ("3rd annual," 1998). As might be expected, the perspective of the physician is clearly present. Selected factors covered in the third edition of the guide are shown in Table 14.

Hoy, Wicks, and Forland (1996) reported on the efforts of six major purchasers to provide information to guide their employee in the selection of health plans. The organizations represented in the paper included Xerox

Corporation, Southern California Edison, Health Insurance Plan of California, Connecticut Business and Industry Association, the Cooperative for Health Insurance Purchasing in Denver, and the State of Wisconsin Employee Trust Fund. All together, the six purchasers represented several hundred thousand beneficiaries. The information presented to employees for selection is similar among the various organizations. Selected factors from the organizations' information are shown in Table 15.

Consumer Surveys

In 1996 and 1997, Health Affairs published several articles reporting on consumer surveys or other assessments of health plan information needed or useful to consumers. In one way or another, the surveys sought to address the issue of health plan quality from the perspective of the consumer. Stephen L. Isaacs, president of the Center for Health and Social Policy, in Pelham, New York, reported on the conduct of a 1995 national survey by Louis Harris and Associates. The survey was known as the "Navigating the Changing Healthcare System probability survey" (Isaacs, 1996). By reviewing the factors reported in the Isaacs paper, one can identify factors that the author, the survey managers, and the respondents may associate with health plan

quality. Selected factors from the Isaacs paper are shown in Table 16.

In another Health Affairs article, Edgman-Levitan and Cleary (1996) reviewed a number of studies by such diverse groups as NCQA, the Agency for Health Care Policy and Research, the Department of Veterans Affairs, The Picker Institute, consumer advocacy groups, and the Kaiser Foundation. Among the objectives of the Edgman-Levitan and Cleary paper was the identification of what consumers consider to represent quality in a health plan. Many factors were repeated in multiple studies reported in the paper. Selected factors from the Edgman-Levitan and Cleary study are shown in Table 17.

Hibbard and Jewett (1997) reported on their study of the factors that should be included in health plan report cards. Hibbard and Jewett conducted both consumer focus groups and consumer surveys to determine which factors were salient and useful to consumers. Selected factors from the Hibbard and Jewett study are shown in Table 18.

Finally, Allen and Rogers (1996) reported on their analysis of six large-scale consumer surveys. The surveys include the Employee Health Care Value Survey discussed above and five other similar surveys. The paper dealt largely with the methodologies of the surveys and does not identify any new rating factors.

A Vision of Quality

In a 1997 Health Affairs article, the well-known health policy author Alain C. Enthoven and Carol B. Vorhaus describe their vision of what a high-quality health care delivery system would look like. The article does not represent a survey or a study, as such, but does identify a number of factors that the authors believe reflect high quality in healthcare delivery. Some of the factors are identified in Table 19 below.

Table 11

Selected Rating Factors From Borowsky Minnesota Study

Continuing medical education
Need for preventive services
Authorization procedures
Implementation of clinical guidelines
Patient outcomes tracking
Patient satisfaction
Patient education materials
Adequate time with patients
Explanations of denials
Specialty care access
Overall plan access
Covered services

Source: JAMA (Borowsky, Davis, Goertz, and Lurie, 1997)

Table 12

Selected Rating Factors From Employee Health Care Value Survey

Plan disenrollment rate
Overall member satisfaction
Choice of physicians
Continuity of care
Cost of care
Willingness to recommend plan
Member intent to switch plans
Access
Covered services
Member information
Paperwork requirements
Coverage
Financial arrangements
Member education
Plan maturity
Overall care
Out-of-pocket costs

Source: (Allen, Darling, McNeil, and Bastien, 1994)

Table 13

Selected Quality Factors From Massachusetts Group Insurance Commission Survey

Plan benefits
Average out-of-pocket costs
Quality of primary care physicians
Premium prices
Participating hospitals/physicians
Quality of specialty physicians
Referrals to specialists
Quality of preventive care
Access to primary care physician
Paperwork requirements
Mental health/substance abuse care
Member satisfaction rate
Independent expert ratings of plan

Source: (Tumlinson, Bottigheimer et al. 1997)

Table 14

Selected Quality Factors From Illinois State Medical Society

Patient satisfaction
Health outcomes
Complaint ratios
Members enrolled
Average premiums
Medical loss ratio
Administrative expense ratio
Profit/loss ratio
Total income
Assets
Financial net worth
Average number of physician visits
Number of participating physicians
Hospital days per member
NCQA accreditation
For profit/not for profit ownership

Source: ("3rd annual," 1998)

Table 15

Selected Quality Factors from Hoy et al

Price
Covered benefits
Organization
Availability
Choice of providers
Structure of plan
Network characteristics
Access to services
Member satisfaction
Wait times
HEDIS Quality Measures
Cost-sharing levels
Number of primary care physicians
Physicians board certified
Wellness and preventive services
Self-referrals for Ob/Gyn

Source: (Hoy, Wicks et al., 1996)

Table 16

Selected Quality Factors From Navigating the Changing Healthcare System Survey

Member education materials
Quality of physicians
Choice of physicians
Courtesy of physicians
Courtesy of physician staff
Access to specialists
Hospital choice
Cost of plan
Ease of making appointments
Convenience of physician office
Paperwork requirements

Source: (Isaacs, 1996)

Table 17

Selected Quality Factors From Edgman-Levitan and Cleary

Plan costs
Covered benefits
Quality of care
Member satisfaction
Physician competence
Coordination of care
Access
Satisfaction with medical care
Communications
Member information
Member education
Waiting times
Choice of hospitals
Comprehensiveness of coverage
Specialty referral process
Premiums
Prescription benefits
Home care coverage
Long-term care coverage
Dental coverage

Table 17 (cont.)

Out-of-plan coverage
Arrangements between plan and providers

Source: (Edgman-Levitan and Cleary, 1996)

Table 18

Selected Quality Factors From Hibbard and Jewett

Mammogram rates
Cervical cancer screening rates
Cholesterol screening rates
Childhood immunization rates
Eye exam rates for diabetics
Hospital post-coronary death rates
Low-birthweight infants
Pediatric asthma admission rates
Postsurgery complication rates
Hospital-acquired infection rates
Cesarean-section rates
Overall quality ratings
Doctor communication ratings
Patient respect ratings
Time spent with physician ratings
Disenrollment rates
Malpractice judgements
Professional organization discipline

Source: (Hibbard and Jewett, 1997)

Table 19

Selected Quality Factors From Enthoven and Vorhaus

Physician skill
Patient satisfaction
Improving patient outcomes
Cesarean section rates
Information systems
Continuous quality improvement
Physician compensation
Patient education
Prenatal childbirth education
Access to emergency care
Referrals
Utilization review
Confidentiality of medical records
Grievance processes
Dispute resolution processes
Information on providers

Source: (Enthoven and Vorhaus, 1997)

Rating Systems in the Popular Literature

The rating systems found in the popular literature generally take the form of report cards, consumer surveys, reviews, consumer guides, standards, and interviews regarding health plan performance. The report cards and surveys varied in the scientific quality of the research. Many were admittedly unscientific and were really popular, consumer-oriented investigative reporting exercises, as were the reviews. The consumer guides were often the by-products of similar studies. There were no surveys or studies in the popular literature focusing on health plans from the hospital perspective. Nonetheless, some of the factors considered may also be important to hospitals, although perhaps for different reasons.

Health Plan Report Cards

One of the first efforts in the popular press to evaluate HMOs was published in Newsweek in 1996. The study evaluated 43 of the largest HMOs on six categories of measurable performance: meeting industry standards, measuring satisfaction, tracking members' health, prevention and screening efforts, maternity care, and customer satisfaction (Spragins, 1996). Enrolled membership and

complaint ratios were also noted but were not included in ratings. Within the various categories, a number of factors were considered. Many of the measurements and the standards used for comparison were largely to the standards of NCQA and HEDIS. A summary of the factors considered in the ratings is shown in Table 20.

A few months later in 1996, U.S. News & World Report published the previously referenced ratings of 174 HMOs in 42 states and the District of Columbia. The article claims to report on "the first rigorous national effort to give consumers comparative information about HMO quality" (Rubin, 1996, p. 52). The study relied largely on the data reported in NCQA's first Quality Compass report. U.S. News & World Report followed up with an update in 1997 and published a significantly revised study for 1998.

In the 1998 U.S. News & World Report, the magazine rated 271 managed care plans, including 87 point-of-service plans (Shapiro, Lord, and Comarow, 1998). The significant changes from the 1997 report were mainly in ranking methodology, which was essentially based on a percentile ranking and the use of a "star rating" of one to four stars. The ratings were still based largely on the NCQA Quality Compass report. The content of the NCQA ratings have been previously summarized in this paper.

Innumerable report cards have been published in local

newspapers, regional magazines, and national business dailies. For example, a 1997 report card on local HMOs was published in the Charlotte Observer based on the NCQA Quality Compass report (Jamieson, 1997). This too was an update on the author's similar report card article in the previous year (Jamieson, 1996). The Wall Street Journal also reported on efforts of the "Big Three" Detroit auto makers' efforts to develop a report card (White, 1998). This report card was also based on NCQA data which has been previously described.

The Oregonian, Portland's daily newspaper, reported on a local survey conducted by a coalition of local employers (Rojas-Burke, 1999). The survey was sponsored by the Oregon Coalition of Health Care Purchasers and covered 11 Portland health plans. The survey was conducted between April and July 1998 from a random sample of members of each of the health plans. The survey utilized the HCFA-developed Consumer Assessment of Health Plans (CAHPS) instrument. Accordingly, no new factors were identified beyond those already identified above under the discussion of CAHPS.

Consumer Surveys

Reporting of numerous consumer surveys regarding managed care health plans are available in the popular

literature. A survey conducted by Sachs Group, Inc., of Evanston, IL, was reported in Hospitals & Health Networks (Cerne, 1994). The survey reflected the opinions of 5,000 household participating in HMOs. A sample of the factors measured in this survey is shown in Table 21.

This survey by the Sachs Group spawned an annual survey by the firm. The 1999 survey reflected responses from about 100,000 consumers in 140 health plans in 34 large city markets (Rauber, 1999).

In August 1996, Consumer Reports published its report on a survey of 30,000 readers who were members of HMOs and preferred provider organizations. The survey sought to "discover what makes a good or a bad health plan" ("How good is," 1996, p. 29). The authors of the study theorized that members' experiences reflect a significant perspective on evaluation of health plans. The factors evaluated in the survey are shown in Table 22.

Time magazine reported on the results of a 1998 survey it sponsored jointly with Cable News Network (Gorman, 1998). The survey of 1,024 Americans included questions, which generally compared Americans' satisfaction with care under managed care health plans versus care under traditional insurance plans. Selected factors considered in the survey are shown in Table 23.

For its third annual HMO ratings project, Newsweek

changed its methodology. While previous reports had relied heavily on NCQA and HEDIS data, as reported above, the 1998 study utilized a consumer survey to "get beyond publicly reported statistics" (Spragins, 1998, p. 62). The factors covered in the survey are summarized in Table 24.

Rating Reviews

A number of other authors have noticed the plethora of studies, papers, and articles purporting to rate health plans. This has created another genre of studies, papers, and articles devoted to reviewing and critiquing the ratings. Often these reviews identify the factors that the various rating schemes reviewed have employed. Hence, they may identify factors that are relevant and important to hospitals.

One of the earliest of this genre focused on reviewing the growing number of surveys of consumer satisfaction with managed care. The author, Karen Donelan, Sc.D., of the Harvard School of Public Health, reviewed six surveys conducted in 1995 (1996). Although the focus of the review was primarily on the methodology employed by the surveys, it is possible to glean some of the factors surveyed from the report. Selected factors from this study are shown in Table 25.

Writing in CFO Magazine in March 1997, Joseph McCafferty made note of the "cottage industry" that has developed for reviewing and rating health plan quality (McCafferty, 1997). Selected factors considered in the ratings efforts reviewed are shown in Table 26.

McCafferty also reports on one of an increasing number of employers who are developing their own evaluation and rating schemes. Trinova Corp., lacking confidence in plan-conducted customer satisfaction surveys and considering the NCQA accreditation insufficient, has developed its own measurement scheme. Based on a 100-point scale, the Trinova scheme measures plan characteristics, membership and utilization, financial measures, preventive care, and health plan management (McCafferty, 1997). Selected factors from the Trinova rating system are shown in Table 27.

In an article published in the August 1997 issue of Business & Health, Shelly Reese (1997) reviewed a number of surveys, focusing on the need for standardization of member satisfaction survey instruments. Factors mentioned in the article from the surveys reviewed are shown in Table 28.

Modern Healthcare also published a review of a number of health plan rating efforts in April 1998 (Kertesz, 1998). Most of the rating efforts reviewed were based on NCQA accreditation standards and HEDIS standards previously discussed. However, the article also provided a limited

review of the content of several on-line web sites containing information allowing the comparison of health plans. Some of the factors reported in the referenced web sites are shown in Table 29.

Consumer Guides

Articles in the form of consumer guidance or checklists are a natural offshoot of the evaluation and rating of health plans. Sometimes the authors identify factors for consideration beyond those regularly covered in other evaluation and rating schemes. Ellen Spragins, author of the first Newsweek article referenced above, followed her Newsweek ratings article with "10 tips" published in Business & Health the following October (Spragins, 1997). Some of her measures are based on HEDIS measures. Some are her own recommendations. A summary of the factors of her "10 tips" is shown in Table 30.

Sources as diverse as Parade Magazine, the Sunday newspaper supplement, and The Wall Street Journal also entered the "consumer guides" chase. The Wall Street Journal entry provides consumer guidance on the fallibility of the rating schemes (Jeffrey, 1997). It did offer some factors to help readers determine whether a health plan's quality claims pass muster. Selected factors are shown in

Table 31.

The Parade Magazine entry was oriented to guiding consumers in obtaining quality care from their HMO (Ubell, 1997). Author Earl Ubell provides a number of considerations in evaluating health plans. A summary of his recommendations is shown in Table 32.

Managed Care Magazine authors Frank Diamond and Michael D. Dalzell (1998) conducted numerous interviews regarding managed care quality. Their article was interestingly oriented to identifying factors that indicate lack of quality in health plans. Their interviews with experts, produced the factors shown in Table 33.

Table 20

Selected Quality Factors from Spragins

Accreditation status
Affiliated hospital accreditation status
Physician board certification
Member satisfaction
Physician satisfaction
Vaccination rates
Mammography rates
Cervical cancer screening rates
Eye exams for diabetics
Cesarean section rates
Prenatal childbirth education
Normal delivery after C-section
Complaint rates
Enrollment

Source: (Spragins, 1996)

Table 21

Selected Quality Factors From Sachs Group

Willingness to recommend
Member turnover rates
Member satisfaction
Satisfaction with coverage
Physician office waiting time
Range of services
Access to out-of-plan physicians
Quality of physicians

Source: (Cerne, 1994)

Table 22

Quality Factors From Consumer Reports

Member satisfaction
Problems getting care
Availability of physicians
Choice of physicians
Relationship with physician
Preventive care notices
Preventive screenings
Waiting time for physician
Satisfaction with service
Profit status
Accreditation status

Source: ("How good is," 1996)

Table 23

Selected Quality Factors From Time/CNN

Satisfaction with coverage
Health plan "hassle"
Confidence in coverage
Trust in providers
Trust in HMOs
Choice of physicians
Emergency coverage
Access to specialists
Appeal process
Right to sue managed care plan

Source: (Gorman, 1998)

Table 24

Selected Quality Factors from Newsweek Poll

Availability of pediatricians
Disease management programs
Geriatricians on staff
Member satisfaction
Accreditation status
Staying healthy
Satisfaction with care

Source: (Spragins, 1998)

Table 25

Selected Quality Factors from Donelan

Member satisfaction
Ease of making physician appointments
Comfort with providers
Availability of services
Waiting time for primary care
Access to specialists
Choice of physicians
Access to tests
Access to emergency services

Source: (Donelan, 1996)

Table 26

Selected Quality Factors from CFO Magazine

Accessibility of care
Adequacy of services
Cost-effectiveness of care
Member satisfaction
Health status of patients

Source: (McCafferty, 1997)

Table 27

Selected Quality Factors from Trinova Corp.

Members per primary care physician
Percentage of closed practices
Percent capitated primary care physicians
Percent salaried primary care physicians
Members per specialty care physician
Physician turnover rate
Members per hospital ratio
Enrollment growth
Percent Medicare/Medicaid enrollment
Percent single contracts
Average age of members
Average family size among members
Inpatient discharges per 1,000 members
Inpatient days of care per 1,000 members
Inpatient average length of stay
Cesarean-section rates
Member disenrollment rate
Childhood immunization rate
Mammography screening rate
Prenatal care rate
Percent members visiting PCP in past 3 years
Member services staff per 1,000 members

Table 27 (cont.)

Percent of aborted calls
Average time on hold
State grievances per 1,000 members
Percent claims paid in 30 days
Average days work on hand

Source: (McCafferty, 1997)

Table 28

Selected Quality Factors from Business & Health

Member satisfaction
Willingness to recommend
Access to plan representatives
Satisfaction with specialists
Respect from physician office staff
Quality of medical care
Convenience of providers
Waiting time in physician office

Source: (Reese, 1997)

Table 29

Selected Quality Factors From Kertesz

Costs
Premiums
Services available
Formularies
Member satisfaction
Access to care
Ability to contact physicians
Courtesy of physician office staff
Office waiting time
Outcomes of care

Source: (Kertesz, 1998)

Table 30

Quality Factors Spragins "10 Tips"

Longevity in industry
Accreditation status
Quality reporting
Heart bypass rates
Angioplasty rates
Cervical cancer screening rates
Breast cancer screening rates
Cesarean section rates
Diabetic eye testing rates
Mental illness coverage
Physician availability
Provider satisfaction
Physician turnover rate
Member satisfaction
Corporate ownership status

Source: (Spragins, 1997)

Table 31

Selected Quality Factors from Jeffrey

Performance measurement efforts
Physician care support programs
Physician performance measurement
Chronic illness management programs

Source: (Jeffrey, 1997)

Table 32

Selected Quality Factors from Parade Magazine

Access to specialists
Chronic disease management
Prescription drug coverage
Preventive care coverage
Access to out-of-network physicians
Specialist referrals
Convenience of providers
Physician manner
Time spent with physician
Physician office staff courtesy
Member satisfaction
Complaints status
Accreditation status

Source: (Ubell, 1997)

Table 33

Indicators of Poor Quality from Managed Care

Claims processing promptness
Approvals promptness
Patient questions go unanswered
System inefficiencies
Poor provider relations programs
Client turnover rates
Accreditation status
Formulary restrictiveness
Specialist quality
Long or short-term focus
Failure to pay bonuses to providers

Source: (Diamond and Dalzell, 1998)

Other Surveys and Rating Efforts

In addition to surveys and rating efforts reported in the professional literature and the popular literature, numerous other surveys and rating efforts are conducted every year for the purpose of evaluating or rating health plans. Some are published in the form of internet web sites or web pages and some are conducted and reported as internal efforts of professional organizations, academic studies, consumer organizations, or business coalitions. Some of these surveys, ratings, and studies are conducted by physician or hospital organizations and, therefore, clearly include measurements and factors that are important to providers of medical care. Other surveys and ratings may include measurements and factors, which may be important to hospitals. A sample of these surveys and ratings are summarized below.

Consumer Satisfaction Surveys

The Michigan State University Institute for Public Policy and Social Research conducted telephone surveys of over 1,000 Michigan residents in each of the years 1995 (Hogan, Goddeeris, and Gift, 1996) and 1997 (Hogan and Mickus, 1998). The surveys focused on consumer views

regarding health policy and managed care in the State of Michigan. The 1995 survey consisted of 30 questions, some of which deal with specific measurements or performance factors. The factors from selected questions are summarized in Table 34.

The 1997 survey included essentially the same questions as the 1995 survey; thus, no new factors were identified.

Physician Ratings of Health Plans

Many surveys of physicians were located in the literature search. Most were focused on issues that would be primarily of interest to physicians only. However, some focused on issues that would be generally of interest to all providers of healthcare services. Reports of two such surveys are summarized here.

Professor Jay Wolfson (1996) of the University of South Florida College of Public Health conducted the previously referenced survey of physician members of the Hillsborough County (Florida) Medical Association. The 18 question survey instrument was distributed to about 800 physicians with 104 responses. The survey asked the physicians to rate, on a scale of 1 to 5, the major HMOs operating in the Hillsborough County (Tampa) area. Selected factors rated in the survey are shown in Table 35.

In 1998 the Pacific Business Group on Health and the American Medical Group Association sponsored a survey of 153 of the largest physician groups in California (Physician groups, 1998). This survey also requested that physicians rate the 10 largest HMOs in California on their contracts with the HMOs. A surprising 71 responses (46%) were received from groups representing 518 contractual relationships between the HMOs and physicians. Selected factors from the survey are shown in Table 36.

Hospital Surveys

Several very pertinent surveys of hospitals were located. An unpublished survey conducted by the North Carolina Chapter of the Healthcare Financial Management Association sought to rate the largest managed care organizations in North Carolina on their "provider friendliness" (Lois L. Priest, letter to HFMA Hospital Members, July 30, 1998). The survey instrument was a very complex document consisting of eight pages and 22 questions. At last count, response had been low, probably due to the complexity of the survey instrument. Nonetheless, being a survey document developed by the leading organization for hospital financial managers, the survey clearly indicates factors that are considered important to hospitals

participating in managed care plans. Selected factors are shown in Table 37.

A very relevant survey of hospitals was sponsored by the Healthcare Association of Southern California (HASC). An independent contractor conducted the survey in 1996, 1997, and 1998. Only the 1998 survey results (1998 Satisfaction, 1999) were publicly released. The survey rated the satisfaction with health plans in the six-county area of Los Angeles among 76 of HASC's 177 member hospitals surveyed (43%) and represented 883 contractual relationships. Being a survey of hospitals conducted by a hospital trade association, the factors surveyed are clearly of interest to hospitals. Interestingly, each factor was also rated on its importance to the hospitals. Selected factors from the HASC survey, with percent classifying as "extremely important" in parentheses, are shown in Table 38.

Table 34

Selected Factors from Michigan State Univ. State of the State Survey 96-15

Use of primary care physician
Referrals to specialty physicians
Limitations on use of pharmacies
Use of generic drugs required
Choice among health plans
Number and diversity of physicians
Plan's reputation for quality
Convenience of physician location
Cost of the plan
Member satisfaction
Amount of paperwork required
Plan handling of inquiries
Technical skills of providers
Personal manner of providers
Coverage for prescription drugs

Source: (Hogan, Goddeeris, and Gift, 1996)

Table 35

Selected Factors from Wolfson

Adequate numbers of primary care physicians
Ease of approval for specialty care
Ease of approval for emergency care
Ease of approval for psychiatric care
Ease of approval for rehabilitative services
Flexibility of prescription drug policies
Ease of verifying patient eligibility
Ease of pre-authorization for services
Sufficiency of hospital network
Wellness and prevention programs
Communication of benefit limits to providers
Communication of benefit limits to members
Availability of provider relations staff
Availability of medical director
Provisions for out-of-area care
Standards of care and treatment

Source: (Wolfson, 1996)

Table 36

Selected Factors from Pacific Business Group on Health and American Medical Group Assoc.

Consumer education
Data reporting
Prescription drug formularies
Quality of care
Referrals to specialists
Services to providers
Overall provider relations

Source: (Physician groups, 1998)

Table 37

Selected Factors from North Carolina Healthcare Financial Management Association

Necessary information shown on ID card
Members' knowledge of requirements and benefits
Ease of obtaining eligibility and benefit information
Ease of obtaining certifications and authorizations
Response time for certifications and authorizations
Ease of appealing coverage decisions
Communication of employer lists to providers
Ease of filing electronic claims
Claim processing time
Ease of obtaining claim status
Provider relations responsiveness
Identifying account on payments and correspondence
Identifying payer on payments and correspondence
Identifying adjustment amounts on payments
Accuracy of payments
Correction of erroneous payments
Services "carved out"
Compensation methods used
Use of exclusive contracts
Providing appropriate medical record releases

Table 37 (cont.)

Prior notification of on-site reviews
Knowledge of health plan staff

Source: Lois L. Priest letter, July 30, 1998

Table 38

Selected Factors from Healthcare Association of Southern California

Accuracy of payments (93%)
Timely verification of eligibility and benefits (89%)
Timeliness of payments (87%)
Accuracy of eligibility reports (81%)
Clearly defined provider/plan responsibilities (81%)
Ease of reconciling payment with reports (73%)
Resolution of disputed capitation payments (72%)
Overall fairness of contract (70%)
Resolution of disputed fee payments (66%)
Provider relations responsiveness (66%)
Timeliness of patient eligibility reports (66%)
Responsiveness to requests for contract changes (61%)
Willingness to resolve issues (56%)
Timely encounter data (44%)
Plan negotiating style (41%)
Accuracy of encounter data reports (40%)
Accuracy of provider manuals (33%)
Willingness to standardize formats (23%)

Source: (1998 Satisfaction, 1999)

Other Potential Rating Factors in the Literature

In addition to papers, articles, guides, and other publications aimed at evaluating and rating health plans, there are numerous papers and articles in the popular literature, in which providers express their particular perspective on health plans. Authors typically are motivated to write about something that stirs their passion. This is clearly the case when providers write about health plans. Providers write about aspects of health plans and their effect on the provision of healthcare services. A close review of these papers and articles often reveals that the papers discuss characteristics of health plans that are of great importance to providers and that potential rating factors can be identified from the articles.

These articles fall into several categories. Most frequently, the content of these articles deals with various contractual issues between providers and health plans. Other articles deal with a genre of legislative actions that are variously described as "patients' rights" legislation or legislation that results from some sort of "backlash" against health plans. Other articles deal with various aspects of health plan performance from the provider perspective and still others prescribe strategies for dealing with health plans. A final category deals with

various administrative characteristics and practices of health plans. A sample of these papers and articles and the rating factors indicated is summarized below.

Contracting Factors

The willingness of hospitals, physicians, and other ancillary providers to contract with health the plans has a direct impact on patients' access to care. The terms of any contract entered into by a provider may even have an impact on the quality of care rendered to patients under a particular plan. Obviously, contracts unfavorable to providers are less likely to achieve high provider participation, thus restricting patient access to providers. Contracts that are overly restrictive, administratively burdensome, or include adverse financial incentives, may have an impact on the level of care that is rendered to a patient under such a contract.

A frequent topic in the literature is the topic of "silent PPOs." Silent PPOs are a breed of managed care organization (MCO) whose principal function is to generate discounts for payers. The discounts agreed to by providers are then secondarily marketed to payers strictly for their cost savings. Often they are marketed on a percentage of savings basis, which means that the higher the bill, the

higher the absolute value of the discount and the more the silent PPO gets paid for access to the network.

This type of network MCO obviously operates in a way that is contrary to the principles of managed care. Moreover, the silent PPO extracts its discount without any offsetting benefit or quid pro quo to the provider. The patient steerage effect usually expected in return for preferential pricing is nonexistent with the silent PPO. Members usually do not have ID cards or provider directories, thus no steerage occurs. Often neither the member nor the provider knows that a network has been used until a discount is claimed on the explanation of benefits.

In a 1995 advisory notice to its members, the Healthcare Financial Management Association warned against silent PPOs and prescribed contract terms aimed at thwarting silent PPOs ("Advisory Notice," 1995). Key terms specifically identified are shown in Table 39.

An article published in Healthcare Financial Management also provides specific contractual protections against silent PPOs (Belt and Ryan, 1998). Key suggestions are shown in Table 40.

A common theme in several articles was the theme of negotiating aggressively with health plans. A trio of articles published in Healthcare Financial Management in 1993, 1995, and 1996 encouraged providers to pay close

attention to contract terms and organizational preparedness for contracting with health plans. Christine Shapleigh, M.D., encouraged recognition that managed care contracting requires an integrated institutional commitment to ensure success (Shapleigh, 1993). She also prescribed several contracting cautions. These factors are shown in Table 41.

Bruce Clark, J.D., also provided key factors to include when negotiating managed care contracts with health plans (Clark, 1995). A summary of the key factors identified is shown in Table 42.

In the third article, Sandra Elliott urged providers to take control of the contracting process (Elliott, 1996). She urged providers to avoid being sucked into a frenzy of contracting activity and specified key points for negotiation. These factors are summarized in Table 43.

A final theme deals with encouraging providers to " just say no" to bad managed care contracts. Author Kathleen Weaver, M.D., (1997) lists a number of factors to consider in contracting with health plans. A summary of her factors is shown in Table 44.

In a July 1996 article in Managed Care Magazine, Susan A. Gibbs, J.D., identified a number of contract factors that she believes should be provider "deal-killers" in contracting with health plans. Selected factors from the article are shown in Table 45.

In the same vein, Charlotte Huff (1998) wrote in Hospitals & Health Networks about egregious terms showing up in new health plan contracts. According to Huff, these contracting factors and others are dealt with in the American Medical Association's proposed model provider contract. Selected factors from the Huff article are shown in Table 46.

Finally, in another article in Managed Care Magazine, five attorneys identify the most problematic HMO contract clauses they have seen (Epstein, 1996). The contracting factors related to the problematic clauses are shown in Table 47.

Legislative Actions

Numerous laws affecting health plans have been enacted in the last few years. Many have taken the form of "patient protection" legislation designed to cure a narrow perceived grievance with the way health plans are administered.

These narrow "healthcare reform" bills have dealt with such issues as minimum hospital stays for obstetrics cases to reform the "drive through deliveries" that some plans are have been accused of requiring. Some have dealt with definitions of "emergency" to make it more difficult for health plans to retroactively deny payment for emergency

room care. Still others have been promoted and passed for the benefit of some healthcare constituency, often in the guise of patient protection. So called "any willing provider" legislation is often promoted as providing choice to the patient, when in fact they are usually promoted by provider groups that have found themselves left out of health plan provider panels.

Numerous bills are introduced and passed in the state legislatures every year and some are passed by Congress at the federal level. Often these bills focus on issues that are important to providers and, thus may identify measurement or rating factors that are important to hospitals and other providers. As this paper is being written, in September 1999, nearly 200 bills relating to healthcare have been introduced in the 106th Congress (Roslokken, 1999). A review of a sample of these bills and their content will identify some measurement factors that may be important to hospitals and other providers.

Among the nearly 200 bills introduced in the 106th Congress, seven of the major bills, along with Department of Labor and White House proposed patient protection regulations were reviewed in an April 1999 article in Business & Health (Roslokken). The seven major bills reviewed are: Patients' Bill of Rights (S6/S240, Daschle and HR358, Dingell), Patient Bill of Rights Plus Act (S300,

Lott), Patient Bill of Rights Act (S326, Jeffords), Promoting Responsible Managed Care Act of 1999 (S374, Chaffee), Access to Quality Care Act of 1999 (HR216, Norwood), Patient Protection Act of 1999 (HR448, Bilirakis), and Managed Care Reform Act of 1999 (HR719, Ganske). Selected factors that may be important to providers from these proposed regulations and legislative acts are shown in Table 48.

Plan Performance Factors

The medical loss ratio is often cited as an indicator of plan quality. James C. Robinson, of the University of California School of Public Health, is critical of the use of this accounting ratio as an indicator of health plan quality. Writing in the July/August 1997 issue of Health Affairs, Robinson makes a convincing case for his position. Nonetheless, hospitals and other providers know that health plans are constrained by the market in their premiums, the denominator of the medical loss ratio and that, therefore, a plan's medical loss ratio is at least an indicator or the stringency of the plan's medical management. Providers empirically know that stringent medical management often is predictive of a high "hassle factor" and reduced compensation for services provided, relative to other plans

in the market. Thus, even in proclaiming its lack of usefulness, Robinson is identifying the medical loss ratio as a factor of interest to providers. Plan performance factors mentioned by Robinson that may be of interest to hospitals are shown in Table 49.

Provider Strategies

Indications of the factors that concern providers in dealing with health plans can be found in the strategies that providers developed in response to the growth of managed care beginning in the early 1990s. While there were numerous articles that included suggestions on provider strategies for dealing with managed care plans, a trio of articles published in Healthcare Financial Management was focused completely on such strategies.

The first of these was published in 1992 by authors Michael Weinstein and Nellie O'Gara. In the article, the authors identify factors that hospitals should research and evaluate in developing their strategies for dealing with the growth of managed care plans. These factors are shown in Table 50.

The other two articles, published in 1997, focused much more on the internal operations of hospitals in a managed care environment. One of the articles does, however,

identify criteria that providers should use in evaluating participation in managed care plans (Alexander, 1997). The factors identified are shown in Table 51.

Administrative Practice Factors

A number of articles written by or reflecting the perspective of hospitals and other providers were generally focused on the administrative practices of health plans. The articles generally identified what the authors considered to be egregious practices of health plans. An example of these articles is presented here.

David Anderson (1997), a public health consultant writing in Business & Health, discussed a number of practices affecting physician's practice of medicine under health plan contracts. He identified a number of factors that, while important to physicians, may also be important to hospitals. Interestingly, he presents information that some studies have shown that some of the more restrictive practices of health plans have produced less favorable clinical and financial results than less restrictive versions of the same practices. Selected factors that may be important to hospitals are shown in Table 52.

The president of the Mecklenburg County Medical Society in Charlotte, North Carolina, Dr. Michael Miltich, like many

other physicians in state and national positions of leadership of the medical profession, has similar opinions. In an interview published in the Charlotte Business Journal, Dr. Miltich expressed some of the factors that he believes are most damaging about health plans (Smith, 1998). A selection of those factors is shown in Table 53.

One of Dr. Miltich's concerns was the fact that most members and patients do not understand their health plans. They do not understand what is covered and not covered, and they do not understand the many procedural requirements of their plans. The provider is usually the point at which a member finally is made to understand the requirements of their health plan. Often this is when they must be told that a service they need or want is not available under their plan or that they must pay more than they expected because they did not follow the "gatekeeper" referral requirements or did not get proper approvals. At this point, the provider is the bearer of bad news and becomes the object of the patient's ire. A 1993 paper published in Health Affairs, documented that most enrollees in a limited scope survey did not understand how their health plans operated (Garnick et al., 1993).

The June 1997 issue of Managed Care Magazine published an article by Contributing Editor Linda Wolfe Keister that discussed the "hassles" that providers face in day-to-day

operations with health plans. The article included a list of the "top managed care hassles." This list is shown in Table 54.

Table 39

Selected Contracting Factors from Healthcare Financial Management Assoc.

Term of contract
Data reporting requirements
Enrollment
Payment deadlines
Notice of addition on new payers
Use of member ID cards
Confidentiality of rates
Patient financial incentives
Guarantor clearly identified

Source: ("Advisory Notice," 1995)

Table 40

Selected Factors from Belt and Ryan

Payer contracts required
Use of logo on member ID cards
Limited provider network in area
Exclusive geographic use of network
Clear identification of payers
Definition of terms of payer agreements
Right to terminate on payer level
Right to approve payer additions
Confidentiality of rates

Source: (Belt and Ryan, 1998)

Table 41

Selected Factors from Shapleigh

Identification of services to be provided
Payment accuracy
Appropriateness of discounts taken

Source: (Shapleigh, 1993)

Table 42

Selected Factors from Clark

Identification of services to be provided
Authorization procedures
Dispute resolution procedures
Definition of emergency care
Definition of medical necessity
Timeliness of authorizations
Claims submission deadlines
Claim documentation requirements
Payment deadlines
Coordination of benefits language
Stop-loss provisions
Utilization review standards
Indemnification language
Liability insurance requirements
Term of agreement
Termination language
Assignment provisions

Source: (Clark, 1995)

Table 43

Selected Factors from Elliott

Plan enrollment
Plan discount levels
Patient financial incentives
Physician incentives
Range of services to be provided
Plan medical loss ratio
Patient volumes expected
Pricing structure
Plan physician panel
Access to plan performance data

Source: (Elliott, 1996)

Table 44

Selected Factors from Weaver

Plan ownership status
Medical director qualifications
Longevity in market
History of timely payment to providers
Market share
Service area
Member disenrollment rate
Accreditation status
Physician turnover rate
Membership enrollment
Plan's general reputation
Current provider panel
Convenience of hospitals and ancillaries
Authorization requirements
Appeals process
Compensation structure
Financial and nonfinancial provider incentives
Deadline for submitting claims
Deadline for paying claims
Indemnification language
Term of agreement
Termination language

Table 44 (cont.)

Amendments by mutual agreement
Dispute resolution process

Source: (Weaver, 1997)

Table 45

Selected Factors from Gibbs

Indemnification requirements
Confidentiality ("gag") clause
Noncompetition clause
Arbitration requirements
"Most-favored nation" clause

Source: (Gibbs, 1996)

Table 46

Selected Factors from Huff

Definition of medical necessity
Termination language
Access to medical records
Amendment by mutual agreement
"Gag" language
Definition of "clean claim"
Payment deadlines
Indemnity requirements

Source: (Huff, 1998)

Table 47

Selected Factors from Epstein

Standard of care
Indemnification requirements
Incentive management fees to plan
Continuation of coverage provisions
Amendment by mutual agreement

Source: (Epstein, 1996)

Table 48

Selected Factors from Legislation Introduced in the 106th Congress

Prompt claims payment
Promptness of requests for further information
Arbitration requirements
Appeals processes
Timely decisions on appeals
Guaranteed coverage of emergency care
Access to specialists
Rights to appeals
Anti-gag clause provisions
Determination of medical necessity
Protection of patient confidentiality
Prohibition of retaliation
Access to out-of-network specialists
Access to out-of-network emergency services
Continuity of care requirements
Formulary limitations
Choice of primary care physicians
Quality reporting requirements
Timeliness of authorizations
Limitations on retrospective review

Source: (Roslokken, 1999)

Table 49

Selected Factors from Robinson

Medical loss ratio
Ownership status
Administrative cost ratio
Profit ratio
Premiums
Patient satisfaction
Clinical outcomes
Per-member-per-month expenses
Provider networks
Benefit packages
Member cost-sharing requirements
Utilization management processes
Enrollment

Source: (Robinson, 1997)

Table 50

Factors from Weinstein and O'Gara

Use of "gatekeepers"
Provider panels
Plan enrollment
Plan financial position
Plan payment methodologies

Source: (Weinstein and O'Gara, 1992)

Table 51

Factors from Alexander

Plan market strength
Provider exclusivity opportunity
Patient steering practices
Provider panel

Source: (Alexander, 1997)

Table 52

Selected Factors from Anderson

Gag clauses
Access to physicians
Access to out-of-network physicians
Compensation methodologies
Equitable compensation
Formularies
Authorization requirements
Primary care gatekeeping
Access to specialists
Appeals processes
Financial incentives for physicians
Patient satisfaction
Ownership status
Physician satisfaction
Physician turnover

Source: (Anderson, 1997)

Table 53

Selected Factors from Miltich

Approval requirements
Timeliness of approvals
Complexity of the plan requirements
Member education

Source: (Smith, 1998)

Table 54

"Top managed care hassles"

Authorization requirements
Referral processes
Eligibility determinations
Utilization review processes
Threats of termination
Termination of contracts
Compensation issues
Timeliness of payments
Unilateral reductions of bills
Requests for patient information
Professional credentialing
Economic credentialing
Formularies
Laboratory "carve-out" delays
Paperwork requirements
Facility/medical record reviews

Source: (Keister, 1997)

Summary of Rating Factors

The review of the literature on quality ratings and evaluations of health plans confirms that there is very little documented effort to review and evaluate plans from the perspective of hospital providers. Nonetheless, numerous potential rating factors were identified from the existing studies and rating schemes that may be important to hospitals. These factors, as listed in the preceding tables, are summarized in the tables that follow. Factors that appeared in more than one paper with slightly different terminology are consolidated into a single factor. The factors are grouped into domains and the tables in which the factors were originally referenced are shown.

The factors shown in Tables 55 through 65 are among those which may determine a managed care plan's performance and desirability from a provider's perspective. These are the factors that will be investigated by survey to determine their relative importance to acute care general hospitals in evaluating health plan participation.

Table 55

Clinical Performance Rating Factors

Factor	Reference Tables
Beta-blocker treatment after heart attack	2
Eye exams for diabetic patients	2, 4, 18, 20, 30
Antidepressant medication management	2
Cesarean section rate	2, 18, 19, 20, 27, 30
Normal delivery after C-section rates	20
Outpatient drug utilization	2
Conservatism in breast surgery	2
Coping with major depressive disorders	4
Mental health/substance abuse care	13
Foot exams for diabetic patients	4
Blood sugar tests for diabetic patients	4
Disease management programs	7, 24, 31, 32
Glaucoma testing	7
Implementation of clinical guidelines	11
Patient outcomes tracking	11, 14, 19, 29, 49
Time physicians spend with patients	9, 11, 18, 32
Thoroughness of care	8
Continuity of care	12
Coordination of care	17

Table 55 (cont.)

Hospital post-coronary death rates	18
Low-birthweight infants	18
Prenatal care rates	19, 20, 27
Pediatric asthma admission rates	18
Postsurgery complication rates	18
Hospital-acquired infection rates	18
Heart bypass rates	30
Angioplasty rates	30
Breast cancer services	2

Table 56

Preventive Care Performance Rating Factors

Factor	Reference Tables
Childhood immunization rates	2, 7, 18, 20, 27
Adolescent immunization rates	2
Smoking cessation programs	2, 4, 7, 8
Screening mammography rates	2, 4, 7, 8, 18, 20, 22, 27, 30
Cervical cancer screening rates	2, 7, 8, 18, 20, 22, 30
Well-child visit rates	2
Prostrate screening rates	7, 22
Quality of preventive care programs	13, 15, 22, 35
Cholesterol screening rates	18, 22
Staying healthy rates	24,26
Member need for preventive services	11
Percent of members visiting PCP in past 3 years	27
Flu immunization rates	7, 8

Table 57

Medical Management Performance Rating Factors

Factor	Reference Tables
Inpatient utilization rates	2, 7, 27
High-occurrence/High cost DRGs	3
Diabetic patient's hospital days	4
Explanation of denials	11
Reconsideration of denials	6
Prescription compliance rates	7
Hospital days per member rates	14, 27
Inpatient average length of stay	27
Availability of medical director	35
Utilization review standards	42
Utilization review procedures	19, 49, 54
Medical management intrusiveness	1

Table 58

Administrative Process Performance Rating Factors

Factor	Reference Tables
Physician staff knowledge of plan payment requirements	7
Physician staff knowledge of referral procedures	7
Ease of referrals	7, 8, 9, 13, 17, 19, 32, 34, 35, 36, 54
Paperwork requirements	7, 8, 9, 12, 13, 16, 34, 54
Ability to contact plan	7
Coordination of benefits procedures	7
Handling of out-of-network claims	7
Appropriateness of premium billing	7
Authorization requirements	1, 8, 44, 52, 53, 54
Authorization procedures	1, 11, 42
Authorization convenience	1, 35, 37
Authorization promptness	1, 33, 37, 42, 48, 53
Appeals process	8, 23, 37, 44, 48, 52
Customer service processes	8, 9, 33, 34, 28

Table 58 (cont.)

Account service processes	8
Plan decision-making style	8
Plan communications	17
Grievance/dispute resolution processes	19, 42, 44
Plan information systems	19
Payment promptness	1, 27, 33, 37, 38, 44, 48, 54
Average days claims backlog	27
Payment accuracy	1, 37, 38, 41
Prompt correction of disputed payements	37, 38
Promptness of requests for further information	48
Eligibility verification convenience	1, 35, 37, 54
Eligibility verification promptness	1, 38
Accuracy of eligibility reports	38
Provider relations responsiveness	1, 33, 35, 36, 37, 38
Average time on hold	27
Percent of aborted calls	27
Member services staff per 1,000 members	27
Ease of approval for emergency care	35
Ease of approval for psychiatric care	35
Ease of approval for rehabilitative care	35

Table 58 (cont.)

Services to providers	36
Necessary information shown on ID card	37
Communication of employer lists to providers	37
Ease of filing electronic claims	37
Ease of obtaining claims status	37
Ease of identifying account on payments and correspondence	37
Ease of identifying payer on payments and correspondence	37
Ease of identifying adjustment amounts on payments	37, 38
Providing appropriate medical record releases	37
Prior notification of on-site reviews	37, 54
Timely encounter data	38
Accuracy of encounter data	38
Willingness to resolve issues	38
Accuracy of provider manuals	38, 44
Willingness to standardize formats	38

Table 59

Organization and Financial Performance Rating Factors

Factor	Reference Tables
Accreditation status	14, 20, 22, 24, 30, 32, 33, 44
Total membership	3, 6, 14, 20, 39, 43, 44, 49, 50
Enrollment by payer	3, 27,
Disenrollment rate	3, 12, 18, 21, 27, 33, 44
Enrollment trends	10, 27
Enrollment by county/MSA	10
Age/gender enrollment distribution	10, 27
Average member family size	27
Physician turnover rate	3, 27, 30, 44, 52
Years in business	3, 12, 30,44
Long-term or short-term focus	33
Indicators of financial stability	3, 10, 50
Premiums	6, 10, 13, 14, 15, 16, 17, 29, 34, 43, 49
Rate trends	3
Financial leverage	5

Table 59 (cont.)

Operating leverage	5
Asset leverage	5
Spread of risk	5
Reinsurance program	5, 6
Total assets	6, 14
Quality of assets	5
Diversification of assets	5
Principal investments	6
Investments in affiliates	6
Loss reserves	5, 6
Interest rate risk	5, 6
Credit risk	5
Capital structure	5, 6
Net worth	14
Risk-adjusted capital	6
Cash flow	5
Debt service coverage	5
Cash and near cash balances	5, 6
Net income	5, 6, 14
Investment income	5
Revenue composition	5
Quality of management	5
Industry sector	5

Table 59 (cont.)

Lines of business	5, 10
Market risk	5
Market share	5, 10, 44, 51
Event risk	5, 6
Medical loss ratio	1, 6, 12, 14, 43, 49
Administrative loss ratio	6, 14, 49
Profit ratio	14, 49
Cost effectiveness of care	26
Per-member-per-month expenses	49
Ownership status (for-profit or not-for-profit)	10, 14, 22, 30, 44, 49, 52
Plan service area	10, 44
Organization and structure	15
Network characteristics	15

Table 60

Contracting Performance Rating Factors

Factor	Reference Tables
Physician compensation method	8, 19
Physician incentives	43, 52
Member education	1, 11, 12, 16, 17, 19, 35, 36, 37, 53
Financial arrangements with providers	12, 17
Fairness of compensation	1, 52
Risk transfer to providers	1
Contract terms	1
Contract overall equity and fairness	1, 38
Percent capitated primary care physicians	27
Percent salaried primary care physicians	27
Failure to pay bonuses to providers	33
Identification of services to be provided	41, 42, 43
Services "carved out"	37
Hospital compensation method	37, 44, 50, 52
Use of exclusive contracts	37, 51
Provider/plan responsibilities clearly defined	38
Responsiveness to requests for contract changes	38

Table 60 (cont.)

Plan negotiating style	38
Term of contract	39, 42, 44
Data reporting requirements by plan	39, 43
Payment promptness requirements	39, 42, 44, 46
Payer contracts required by PPOs	40
Notice of addition of new payers	39
Right to approve new payers	40
Use of member ID cards	39
Plan logo on member ID cards	40
Communication of benefit limits to providers	35
Confidentiality of rates	39, 40
Patient financial incentives (steerage)	39, 43, 51
Guarantor clearly identified	39, 40
Limited provider network in area	40
Payer exclusive geographic use of network	40
Definition of terms of payer agreements	40
Provider right to terminate on payer level	40
Definition of emergency care	42
Definition of medical necessity	42, 46, 48
Claims submission deadline	42, 44
Claim documentation requirements	42

Table 60 (cont.)

Definition of "clean claim"	46
Coordination of benefits language	42
Stop-loss provisions	42
Indemnification language	42, 44, 45, 46, 47
Liability insurance requirements	42
Termination language	42, 44, 46
Assignment provisions	42
Plan discount levels	1, 43
Provider incentives	44
Amendments by mutual agreement only	1, 44, 46, 47
Confidentiality (gag) clause	45, 46, 48, 52
Prohibition on retaliation for communication with patients	48
Noncompetition clause	45
Arbitration requirements	45, 48
Member right to sue plan	23
"Most-favored-nation" clause	1, 45
Access to medical records	46, 48
Confidentiality of medical records	19
Standard of care language	35, 47
Continuation of coverage requirements	47, 48
Limitations on retrospective review	48
Incentive management fees to plan	47

Table 61

Provider Access Rating Factors

Factor	Reference Tables
Availability of primary care physicians	2, 15, 22, 35
Members per primary care physician	27
Percentage of closed practices	27
Use of primary care physician "gatekeepers"	34, 50, 52
Availability of pediatricians	24
Availability of geriatricians	24
Major depressive disorder providers	4
Number of member physicians	6, 14, 30, 34, 49, 50, 51
Choice of primary care physicians	7, 8, 48
Getting appointment with primary care physician	7, 13
Choice of specialists	7, 10
Members per specialty care physician	27
Access to specialists	11, 16, 23, 25, 32, 48, 52
Choice of hospitals	16, 17, 35
Members per hospital ratio	27
Convenience of hospitals and ancillaries	44

Table 61 (cont.)

Choice of providers	8, 12, 15, 16, 22, 23, 25
Availability of information on providers	19
Access to care	8, 9, 11, 12, 15, 17, 22, 25, 26, 29, 52
Waiting time for physicians	8, 9, 15, 17, 21, 22, 25, 28, 29
Access to physicians by phone	8, 29
Problems finding physician	9
Self-referrals for Ob/Gyn	15
Convenience of physician office	16, 28, 32, 34
Ease of making appointments	16, 25
Times members visited doctor's office	9, 14
Times members visited emergency room	9
Access to emergency care	19, 25
Access to out-of-network emergency care	48
Access to out-of-network physicians	21, 32, 48, 52
Pharmacy access	34
Out-of-area care provisions	35
Plan restrictions on care	8

Table 62

Satisfaction Rating Factors

Factor	Reference Tables
Member satisfaction with care	2, 4, 7, 12, 17, 22, 24
Member satisfaction with interpersonal care	8
Member satisfaction with providers	4, 23, 25
Member satisfaction with choice of providers	4
Member overall satisfaction	4, 7, 9, 11, 12, 13, 14, 15, 17, 19, 20, 21, 22, 24, 25, 26, 28, 29, 30, 32, 34, 49, 52
Member willingness to recommend plan	4, 7, 8, 12, 21, 28
Member trust in plan	23
Member satisfaction with primary care physician	7, 9
Member satisfaction with specialists	7, 9, 28
Member satisfaction with office staff	9, 16, 28, 29, 32
Member satisfaction with pharmacy plan	7

Table 62 (cont.)

Member satisfaction with customer service	7
Member intention to re-enroll	7, 8, 12
Member satisfaction with premium	7
Member reason for selecting plan	7
Member out-of-pocket costs	12, 13, 15, 49
Physician satisfaction with plan	8, 20, 30, 52
Physician satisfaction with care	8
Physician willingness to recommend plan	8
Physician stress/morale	8
Continuing medical education for physicians	11
Member complaint ratio	1, 6, 10, 14, 20, 27, 32
Courtesy of physicians	16
Member satisfaction with coverage	21, 23
Member rating of overall health status	9
Physician manner	32, 34
Member relationship with physician	22
Physician communications ratings	18
Patient respect ratings	18

Table 63

Coverage Rating Factors

Factor	Reference Tables
Range of covered services	11, 12, 17, 21, 26, 29
Plan benefits	13, 15, 17, 49
Prescription drug benefits	17, 32, 34
Use of formularies	29, 36, 52, 54
Flexibility of formulary policies	33, 34, 35, 48
Home care coverage	17
Long-term care coverage	17
Dental coverage	17
Out-of-network coverage	17
Mental illness coverage	30
Preventive care coverage	32
Emergency care coverage	23, 48

Table 64

Provider and Plan Quality Rating Factors

Factor	Reference Tables
Physician board certification rates	3, 15, 20
Affiliation with quality group	6
Hospital quality and reputation	7, 13
Plan quality improvements	8, 19
Quality of primary care physicians	13, 16, 21
Quality of specialist physicians	13, 16, 21, 33
Independent experts' ratings of plan	13
HEDIS quality measures	15
Quality of care	17, 28, 36
Physician competence	17, 19, 34
Overall quality ratings of plan	18, 34, 44
Malpractice judgements against providers	18
Professional organization disciplines	18
Hospital accreditation status	20
Quality reporting	30, 36, 48
Plan performance measurement efforts	31
Physician performance measurement efforts	31
Plan medical director qualifications	44

Table 65

Plan "Hassle" Factors

Factor	Reference Tables
Member "hassle" factor	23
System inefficiencies	33
Complexity of plan requirements	53
Threats of termination	54
Contract terminations	54
Problems with compensation	54
Unilateral reductions of bills	54
Excessive requests for patient information	54
Credentialing problems	54
Economic credentialing	54
Laboratory "carve-out" delays	54

C H A P T E R III

RESEARCH METHODOLOGY

The objective of this study was to provide useful information that will be of practical value in developing a system of rating health plans from the perspective of acute care general hospitals. Achieving this objective required determining whether the major accreditation and rating systems currently available are important to acute care general hospitals' contracting decisions and determining how important each of the more than 300 factors located in the literature search is to hospital contracting decisions. Determining this information required obtaining the opinions of hospital personnel who are knowledgeable of hospital interests in health plan participation.

This primary research study used a self-administered, cross-sectional, mail survey design to determine the importance of major health plan accreditation and rating systems and rating factors to a sample of hospital managed care, financial, and/or executive management personnel. This chapter identifies the participants in the study, the sample and sampling methods utilized, the survey instruments

and data collection procedures utilized, the analysis of the survey data, and the limitations of the research design.

The Preliminary Survey

A preliminary survey was conducted to test the terminology of the questions and to reduce the more than 300 factors identified in the literature review to an appropriate number of factors to be used in the main survey. A convenience sample of 19 subject matter experts was drawn from members of the Healthcare Financial Management Association's Managed Care Forum. The members of the panel of experts are shown in Appendix B. Most of the members of the panel of experts are certified members of Healthcare Financial Management Association, holding certification either as Fellows (FHFMA) or Certified Healthcare Finance Professionals (CHFP). All were employed by acute care general hospitals or by an element of a hospital owned integrated delivery system. Additionally, many of the experts are Certified Public Accountants. Most of the experts were either chief financial officers of their hospitals or were the senior managed care officers of their hospitals.

The panel of experts represented 14 different states and included all geographic sections of the country. Eleven

(58 percent) of the hospitals represented are classified as urban by the Medicare system, according to the respondents. The rest of the hospitals are classified as rural. Hospitals licensed for 200 or more beds were represented by 13 (68 percent) of the experts with the balance from smaller hospitals. Hospitals representing over 9,000 licensed beds participated in the preliminary survey. Thirteen (68 percent) of the hospitals represented markets in which the proportion of gross revenue coming from managed care health plans exceeded 15 percent of total gross revenue. The remaining hospitals had 15 percent or less of their gross revenue coming from managed care health plans. The panel of experts represented a broad cross-section of acute care general hospitals in the nation.

Each member of the panel of experts completed the preliminary survey instrument shown in Appendix A. The preliminary survey instrument used a scaled response mechanism with responses available on the continuum of "not important" to "extremely important." It included all 300+ factors for response. The objectives of this survey instrument were (1) to test the descriptions of the factors and (2) to reduce the number of factors to be included in the main survey instrument.

Appendices C and D show the summary results of the preliminary survey of the panel of managed care experts.

Appendix C shows the mean scores for all factors by domain. This summary also shows the number of experts responding to each question (n) and the standard deviation of the mean for each factor from the overall mean of all factors in the survey (Z-score). The last page of Appendix C shows a summary of the mean scores for all items in each domain.

The 47 factors from the preliminary survey receiving mean importance scores in excess of 4.0, on a scale of zero through five, from the respondents were included in the main survey instrument. The mean importance scores of all factors used in the main survey instrument were at least 1.186 standard deviations from the mean of all factor scores.

It is interesting to note that all of the factors selected for the main survey instrument came from the domains of medical management, "hassle" factors, organization and financial, contracting, and administrative process domains. None of the factors rated most important by the panel of managed care experts came from the domains most heavily covered in the most common plan accreditation and rating systems. This result is shown in Table 66.

Table 66

Main Survey Items by Domain

Domain	Total Items	Main Survey Items
1. Plan accreditation and rating factors	7	7
2. Medical management performance rating factors	11	2
3. Plan "hassle" factors	11	4
4. Organization and financial performance factors	50	1
5. Contracting performance factors	55	24
6. Administrative process performance rating factors	49	16
7. Clinical performance rating factors	28	0
8. Preventive care performance rating factors	13	0
9. Provider access rating factors	33	0
10. Satisfaction rating factors	29	0
11. Coverage rating factors	12	0
12. Provider and plan quality rating factors	17	0

The Main Survey Participants

There are approximately 5,500 acute care general hospitals in the United States. In those hospitals, responsibility for relationships with health plans is commonly assigned to the financial management function of the organization. In smaller hospitals, the chief financial officer is often responsible for health plan contracting. Larger hospitals usually have an executive position dedicated to management of the hospital's relationships with health plans. These positions are variously titled as directors or vice presidents of managed care or business development.

The participants in the main survey were from a sample of the managed care executives, chief financial officers and chief executive officers of the nation's hospitals. A mailing list available from SMG Marketing Group, Inc., contained 5,179 of the approximately 5,500 acute care general hospitals. SMG Marketing Group, Inc., is headquartered in Chicago and since 1985 has developed and maintained proprietary healthcare facility databases. The company maintains 31 separate healthcare and health plan related mailing lists, including their U. S. Hospitals list. The SMG Marketing Group mailing list of U. S. Hospitals contained about 300 more acute care general hospitals than

the American Hospital Association mailing list and was selected for its greater completeness. According to SMG Marketing, their hospital mailing list is developed and maintained by surveys of federal and state licensing bodies, industry associations, regulatory agencies, and accrediting bodies. SMG claims that the addresses on their lists are 99 percent deliverable (SMG Marketing, 1999).

The goal of the study was to produce results that can be relied upon at the level of 95 percent confidence that the results are accurate within plus or minus 5 percent. Setting the population (N) equal to the 5,179 hospitals included in the SMG mailing list, a minimum usable sample size (n) of 384 participants ($n = ((1.96*.5)/.05)^2$) was required, where the Z score for a 95 percent confidence level is 1.96, the assumed true proportion of the sample is set at .5, and the confidence interval is set at .05 (Rea and Parker 1997).

Sample

Expectations of response rates for self-administered, mail surveys are variously reported from as low as 20 percent (Bourque and Fielder, 1995) and as high as 90 percent for specialized groups with extensive follow-up actions (Rea and Parker, 1997). Allowing for a conservative

response rate of 15 percent and modest follow-up activity, survey instruments for the main survey were mailed to 3,000 individuals from the SMG Marketing Group, Inc., hospital mailing list. It was expected that with a 15 percent response rate the minimum of 384 usable responses would be found in the 450 responses anticipated.

A systematic random sample was drawn from the SMG Marketing hospital mailing list. A table of random numbers was used to select the starting point in the list. Thence, every other hospital was selected to receive a survey instrument until a total of 3,000 hospitals had been selected. When a hospital was selected, the name of the managed care executive, if any, was used first. If no managed care executive was identified, the name of the chief financial officer was used. If no chief financial officer was identified, the name of the chief executive officer was used. The final sample consisted of 1,270 managed care executives, 1,174 chief financial officers, and 556 chief executive officers.

The main survey instrument was sent with an accompanying cover letter and a stamped, addressed return envelope. As an inducement to complete and return the survey, recipients were offered a copy of a paper written by the author on the subject of assuring prompt payment from health plans. This topic was identified as most important

to respondents in the Healthcare Association of Southern California hospital survey discussed in Chapter II and was rated fifth out of 300+ factors in the preliminary survey.

Three weeks after the mailing, approximately 25 telephone follow-up calls and approximately 125 e-mail follow-up messages were sent to encourage completion of the survey instrument. A total of 418 responses were received for a 13.9 percent response rate. Most of the responses were received by return mail. About ten percent of the responses were received by facsimile or by return e-mail.

A total of 10 responses were totally unusable and another 20 responses did not have all of the scaled response questions completed. The unusable and incomplete responses were eliminated from the responses upon which the analysis was conducted. Thus, 388 of the responses, representing 12.9 percent of the sample, were used in the analysis.

The Main Survey Instrument and Data Collection

The main survey instrument was virtually identical in form to the preliminary survey instrument. Its scaled response continuum for the plan performance factors was modified to a range from one to five, representing "somewhat important" to "extremely important." The rationale for this change is that the preliminary survey results had already

determined that none of these items was classified as "not important." The scaled response continuum for the plan accreditation and rating factors remained with a range from one to five, representing "not important" to "extremely important." The main survey instrument and the accompanying cover letter are included in Appendix E.

Data Analysis

An important initial consideration in the data analysis is the validity of the survey instrument. Validity of the instrument is considered in two ways. First, the construct validity and secondly, the content validity. The construct validity of the instrument deals with the extent to which the instrument measures the major dimensions of health plan quality. According to Shi (1997) the construct validity of the instrument is strengthened if measurement criteria that are agreed-upon among those that are knowledgeable of the subject are included in the instrument. Sources of such agreed-upon criteria are a literature search, other measurement instruments, and the opinions of experts on the subject.

The extensive literature search conducted for this study resulted in over 300 measurements of all aspects of health plan quality, many of which came from other

instruments that are used to measure health plan quality. Those 300 measures were then submitted to the judgement of a panel of managed care experts to identify those that are of greatest importance to hospitals. This process satisfies Shi's criteria for construct validity.

Content validity deals with the degree to which the response opportunities of the measurement instrument are representative of the dimensions of the study subject. According to Shi (1997), conducting a literature search, referring to other measurement instruments, and obtaining the opinions of experts on the subject also strengthen content validity. The literature search and preliminary survey conducted for this study, then, also satisfy Shi's criteria for content validity.

As the responses were received, they were keyed into a data file in the Statistical Package for the Social Sciences (SPSS) version 9.0. The SPSS software package was then used for statistical analysis of the responses.

The first analysis was performed to establish the reliability of the instrument. The reliability of the instrument deals with the extent to which the instrument produces consistent measurements of the dimensions measured. Internal reliability was assessed using the SPSS facility for calculating Cronbach's coefficient alpha and the SPSS facility for calculating Cronbach's coefficient alpha on

split-halves of the sample. Coefficient alpha was calculated on all 54 of the scale questions as a single scale and on the 47 plan performance factor items of question 1 and the 7 plan accreditation and rating factor items of question 2 as separate scales. The values of coefficient alpha were .9512, .9513, and .9065 respectively. Coefficient alpha was calculated on split-halves of the 47 plan performance factor items of question 1 and the 7 plan accreditation and rating items of question 2 as separate scales. The values of coefficient alpha for question 1 were .8767 for one half and .9442 for the other half. The values of coefficient alpha for question 2 were .9155 for one half and .8511 for the other half. All of these values are well above the minimum value of .70 specified by Shi (1997, p. 270) and suggest very good reliability.

The statistical significance of the responses to the scaled response questions was assessed using the SPSS one sample chi-square test facility. The one sample chi-square test was run on all 54 scaled response questions to test the null hypothesis that no statistical significance exists in the distribution of the responses to the questions. The values for the chi-square statistic for the 54 scaled response questions ranged from 49.706 to 549.345. These values are all well above the critical values of the chi-square distribution of 7.815 and 9.488 for degrees of

freedom equal to 3 or 4, respectively, at the 95 percent level of confidence (Rea & Parker, 1997, p. 170). Accordingly, the null hypothesis was rejected. The distributions of the responses to the survey questions are statistically significant and are different from the distributions that would be expected from pure chance.

Calculation of frequencies and means of the responses to each question by the SPSS package was used to assess the relative importance to the respondents of the various plan performance factors and the plan accreditation and rating factors. The extent to which variances in responses resulted from differences in the demographic characteristics of respondent hospitals was assessed using the SPSS nonparametric correlation facility.

Delimitations and Limitations

The population from which the sample was drawn was limited to acute care general hospitals. These criteria excluded hospitals from selection that were not categorized as acute care general hospitals. Thus, the results of the study cannot be generalized to children's hospitals, rehabilitation hospitals, behavioral care hospitals, or other specialty hospitals. It is important to note that with respect to health plan performance, the interests of

all hospitals are not dramatically dissimilar; however, generalizations to hospitals outside the scope of this study would not be statistically valid.

C H A P T E R I V

RESULTS

The study had three primary objectives represented by three research questions. First was to determine the importance to hospitals of health plan accreditation and ratings of health plans by the major rating systems. Second was to identify health plan performance factors that are important to hospitals, but which are not included in current accreditation and rating systems. The third objective was to identify which health plan performance factors are most important to hospitals.

The Respondents

Among the responses used (n = 388), hospitals in 48 states plus the District of Columbia and the Commonwealth of Puerto Rico were represented. On 14 of the responses used, no state was identified. Of the 388 responses used, 380 responses represented 94,515 licensed beds with a mean size of 249 beds and a median size of 177 beds. The remaining 8 responses did not identify bed size. The responses used

represented predominantly urban (64.2 percent) hospitals, and predominantly hospitals with significant experience with managed care in that 72.2 percent received more than 15 percent of their gross revenue from managed care health plans.

The mean and median bed sizes of hospitals in the sample are not known. The mean and median bed sizes of hospitals responding to the main survey compare reasonably well with the average bed size of 177 for all U. S. hospitals in 1994, as reported by Jones & Simmons (1999). Given that the sample is a large, random selection from the universe of U. S. hospitals, the sample is presumed to have a similar average bed size.

The urban/rural mix of the sample is also not known. The urban/rural mix of hospitals filing cost reports in 1993 reported in the 1995 Almanac of Hospital Financial and Operating Indicators published by the Center for Healthcare Industry Performance Studies (CHIPS) is 61.1 percent urban (Cleverley, 1995, p. 508). The mix of the sample, again being a large, random selection of all U. S. Hospitals, is presumed to have a similar urban/rural mix. Thus, the urban/rural mix of the respondent hospitals compares well with the universe and the presumed mix of the sample.

The managed care revenue mix of the sample is not known. The division point of more than or less than 15

percent of revenue was experientially selected to represent a threshold below which a hospital would be considered to have low managed care penetration. The CHIPS data for 1993 reports that 76.6 percent of the 2,360 hospitals in its database are considered medium or high in managed care penetration of their service area (Cleverley, 1995, p. 509). The sample is presumed to have a similar mix of high and low managed care penetration, thus, the mix of respondents compares reasonably well with the universe of U. S. hospitals and the presumed mix of the sample.

The characteristics of the respondents on Table 67 are similar to the sample and the universe of U. S. hospitals.

Table 67

Characteristics of Main Survey Respondents

Characteristic	No.	Percent
Urban/Rural		
Rural	139	35.8
Urban	249	64.2
Managed Care Penetration		
Less than 15 percent	108	27.8
More than 15 percent	280	72.2

Importance of Accreditation and Ratings

To assess the importance of accreditation and the importance of the two major, national accreditation systems, the respondents were asked to indicate the importance of each on a scale of 1 to 5 representing the continuum from "not important" to "extremely important." These were reflected in questions 2.1 (accreditation by national organization), 2.2 (accreditation by NCQA), and 2.3 (accreditation by JCAHO) of the survey instrument. Table 68 presents the frequency and percentage of responses for each of the five possible responses for these three questions. Table 69 presents means and standard deviations for the responses to these questions. All of the questions had mean importance ratings of 3.00 or less.

Using the SPSS facility for nonparametric correlations, the Spearman rank correlation coefficient (Spearman's rho) was calculated to assess the correlation between the responses to the three questions. There was a strong, statistically significant, positive correlation between the importance ratings of accreditation by a national organization and the importance ratings of specific accreditation by the NCQA ($r(387)=.843, p<.01$). There was also a positive, statistically significant, although only moderately strong correlation between the importance ratings

of accreditation by a national organization and the importance ratings of specific accreditation by the JCAHO ($r(387)=.696, p<.01$). There was a moderately strong, statistically significant, positive correlation between the importance ratings of specific accreditation by NCQA and the importance ratings of specific accreditation by JCAHO ($r(387)=.723, p<.01$). This suggests that respondents that felt that accreditation by a national organization was important felt that accreditation by NCQA and/or JCAHO were also important.

The relationship between the characteristics of the respondents and the importance ratings of accreditation of health plans was also assessed. Using Spearman's rho, no statistically significant correlation between hospital bed size and the ratings of accreditation importance was found.

Urban hospitals tended to place a slightly lower level of importance on accreditation by a national organization and the NCQA specifically than rural hospitals. This was borne out by factor analysis isolating the mean scores for the three questions by the hospitals' urban/rural status. Mean scores for urban hospitals were .35, .28, and .14, respectively, lower for urban hospitals (N = 249) than for rural hospitals (N = 139). Using the Mann-Whitney test, the slightly lower ratings of importance of accreditation by a national organization and specific accreditation by NCQA

given by urban hospitals were found to be statistically significant (p = .005 and .026 respectively). The difference between the importance ratings given accreditation by JCAHO by urban and rural hospitals was not significant at the .05 level.

Using the Mann-Whitney test, the difference in accreditation importance ratings given by hospitals with more or less than 15 percent managed care penetration were not significant at the .05 level.

Table 68

Importance of Plan Accreditation (Frequencies)

Question	Response	Freq.	%
2.1 Plan Accreditation by national organization	1 Not Important	68	17.5
	2	75	19.3
	3	133	34.3
	4	84	21.6
	5 Extremely Important	28	7.2
	Total	388	100.0
2.2 Plan accreditation by National Committee for Quality Assurance (NCQA)	1 Not Important	60	15.5
	2	62	16.0
	3	122	31.4
	4	107	27.6
	5 Extremely Important	37	9.5
	Total	388	100.0
2.3 Plan accreditation by Joint commission on the Accreditation of Healthcare Organizations (JCAHO)	1 Not Important	79	20.4
	2	80	20.6
	3	123	31.7
	4	70	18.0
	5 Extremely Important	36	9.3
	Total	388	100.0

Table 69

Importance of Plan Accreditation (Means)

Question	N	Mean	Std. Dev.
2.1 Plan Accreditation by national organization	388	2.82	1.17
2.2 Plan accreditation by National Committee for Quality Assurance (NCQA)	388	3.00	1.20
2.3 Plan accreditation by Joint commission on the Accreditation of Healthcare Organizations (JCAHO)	388	2.75	1.23

To assess the importance of the four major rating systems, the respondents were asked to indicate the importance of each on a scale of 1 to 5 representing the continuum from "not important" to "extremely important." These were reflected in questions 2.4 (HEDIS), 2.5 (FACCT), 2.6 (A. M. Best Ratings), and 2.7 (Weiss Ratings) of the survey instrument. Table 70 presents the frequency and percentage of responses for each of the five possible responses for these four questions. Table 71 presents means and standard deviations for the responses to these questions. Only the A. M. Best Ratings had mean importance scores of 3.00 or better. All others had mean importance scores of less than 3.00.

The relationship between the characteristics of the respondents and the importance scores for the major systems of rating health plans was assessed using factor analysis and the Mann-Whitney test. Factor analysis revealed that the importance scores for HEDIS ratings and FACCT ratings for were .30 and .28 lower, respectively, for urban hospitals (N = 249) than for rural hospitals (N = 139). The Mann-Whitney test revealed that these differences were statistically significant relationships at the .011 and .016 levels, respectively.

Using Spearman's rho, the relationship between a hospital's bed size and the importance it assigned to HEDIS

ratings ($r(379)=-.125, p<.05$) and the FACCT ratings ($r(379)=-.101, p<.05$) were determined to be weakly negative but statistically significant. This means that larger hospitals were slightly less likely to place high importance on the HEDIS and FACCT ratings than smaller hospitals.

Table 70

Importance of Plan Ratings (Frequencies)

Question	Response	Freq.	%
2.4 Plan's Health Employer Data Information Set (HEDIS) Ratings	1 Not Important	57	14.7
	2	96	24.7
	3	129	33.2
	4	80	20.6
	5 Extremely Important	26	6.7
	Total	388	100.0
2.5 Plan's Foundation for Accountability (FACCT) Ratings	1 Not Important	77	19.8
	2	98	25.3
	3	128	33.0
	4	65	16.8
	5 Extremely Important	20	5.2
	Total	388	100.0
2.6 Plan's A. M. Best Ratings	1 Not Important	43	11.1
	2	74	19.1
	3	132	34.0
	4	97	25.0
	5 Extremely Important	42	10.8
	Total	388	100.0

Table 70 (contd.)

2.7 Plan's rating by Weiss Ratings, Inc.	1 Not Important	54	13.9
	2	81	20.9
	3	140	36.1
	4	80	20.6
	5 Extremely Important	33	8.5
	Total	388	100.0

Table 71

Importance of Plan Ratings (Means)

Question	N	Mean	Std. Dev.
2.4 Plan's Health Employer Data Information Set (HEDIS) Ratings	388	2.80	1.13
2.5 Plan's Foundation for Accountability (FACCT) Ratings	388	2.62	1.13
2.6 Plan's A. M. Best Ratings	388	3.05	1.15
2.7 Plan's rating by Weiss Ratings, Inc.	388	2.89	1.14

Importance of Plan Performance Factors

To assess the importance of the 47 health plan performance factors identified in the preliminary survey, the respondents were asked to indicate the importance of each on a scale of 1 to 5 representing the continuum from "somewhat important" to "extremely important." These were reflected in questions 1.1 through 1.47 of the survey instrument. Table 72 presents means and standard deviations for the responses to these questions.

Table 72

Plan Performance Factors (Means)

Factor	N	Mean	Std. Dev.
1. Plan's medical mgmt. intrusiveness—involvement in patient care decisions	388	3.95	.98
2. Plan's utilization review procedures	388	3.87	.90
3. Unilateral reductions of bills by plan	388	4.49	.82
4. Complexity of plan's requirements of providers	388	4.19	.80
5. Provider problems with plan's compensation	388	4.45	.75
6. Plan's excessive requests for patient information	388	3.98	.89
7. Degree of financial risk transfer from plan to providers	388	4.30	.94
8. Plan's hospital compensation method—disc., per diems, per case, capitation	388	4.16	1.01
9. Amendments by mutual agreement only	388	4.21	.99

Table 72 (contd.)

10. Contract terms—balanced or biased to plan	388	4.30	.81
11. Requirement for plan payment promptness in contract	388	4.38	.81
12. Plan's use of exclusive provider contracts	388	3.49	1.16
13. Plan discount levels acceptable	388	4.44	.79
14. Contract overall equity and fairness	388	4.27	.81
15. Payer contracts required by PPOs to discourage silent PPOs	388	4.09	.97
16. Termination language—balanced and fair	388	4.09	.91
17. No "most-favored-nation" clause	388	4.13	1.08
18. Plan's physician compensation method—fee-for-service, disc., capitation	388	3.54	1.14
19. Plan's usage of patient financial incentives (steerage)	388	3.86	.97
20. Definition of "clean claim"—to start prompt payment clock	388	3.92	.93
21. Confidentiality of rates to discourage silent PPOs	388	3.84	1.05

Table 72 (contd.)

22. Fairness of plan's compensation to providers—relative to other plans	388	4.09	.84
23. Provider/plan responsibilities clearly defined in contract	388	3.96	.90
24. Use of member ID cards with plan logo required	388	3.76	1.17
25. Plan's use of physician incentives—bonuses, capitation add-ons	388	2.80	1.12
26. Limitations on retrospective review and denials	388	3.99	.95
27. Identification in contract of services to be provided	388	3.86	1.03
28. Definition of medical necessity	388	3.78	1.04
29. Confidentiality clause not really a "gag" clause	388	3.35	1.07
30. Arbitration requirements fair	388	3.53	1.01
31. Indicators of plan's financial stability	388	3.71	1.02
32. Plan's promptness in provider payments	388	4.43	.74
33. Plan's rate of payment accuracy—percentage of payments right the first time	388	4.27	.77

Table 72 (contd.)

34. Plan's promptness in correction of disputed payments	388	4.17	.78
35. Degree that necessary information is shown on plan member ID card	388	3.83	1.00
36. Plan's promptness in responding to authorization requests	388	4.11	.86
37. Plan's requirements for authorization of treatment	388	4.05	.88
38. Convenience of plan's member eligibility verification process	388	3.86	.93
39. Plan's promptness in requesting further information needed for payment	388	3.82	.90
40. Plan's average days of claims backlog—degree of payment delays	388	4.21	.86
41. Convenience of plan's authorization procedures for providers	388	3.94	.85
42. Plan's procedures for authorization of treatment	388	3.97	.87
43. Ease of filing electronic claims with plan	388	3.84	1.00
44. Plan's appeals process for medical necessity denials	388	3.92	.89

Table 72 (contd.)

45. Accuracy of plan's eligibility reports	388	3.79	1.02
46. Participating physician's staff knowledge of referral procedures	388	3.43	1.06
47. Plan's promptness in responding to eligibility verification requests	388	3.97	.96

Ranking the responses to the preliminary survey instrument by mean importance scores produced the list of the 47 most important plan performance factors that was used in the main survey instrument. Only those factors with mean importance scores to the panel of experts of above 4.00 were included in the final survey instrument.

Ranking the responses to the main survey instrument by mean importance score allows identification of those among the top 47 that, according to mean importance scores, are most important to hospitals. Again using the criteria of mean importance scores above 4.00 as the cut-off point produces a list of the 20 most important plan performance factors to the hospital respondents. Table 73 lists the top 20 plan performance factors.

Nearly all of the top 20 factors had standard deviation values of less than 1.00 and most of the standard deviation values were among the lowest in the responses, suggesting considerable consensus on the importance of these to 20 factors.

Table 73

Top 20 Plan Performance Factors (Ranked by Means)

Factor	N	Mean	Std. Dev.
1. Unilateral reductions of bills by plan (1.3)	388	4.49	.82
2. Provider problems with plan's compensation (1.5)	388	4.45	.75
3. Plan discount levels acceptable (1.13)	388	4.44	.79
4. Plan's promptness in provider payments (1.32)	388	4.43	.74
5. Requirement for plan payment promptness in contract (1.11)	388	4.38	.81
6. Degree of financial risk transfer from plan to providers (1.7)	388	4.30	.94
7. Contract terms—balanced or biased to plan (1.10)	388	4.30	.81
8. Contract overall equity and fairness (1.14)	388	4.27	.81
9. Plan's rate of payment accuracy—percentage of payments right the first time (1.33)	388	4.27	.77
10. Amendments by mutual agreement only (1.9)	388	4.21	.99

Table 73 (contd.)

11. Plan's average days of claims backlog—degree of payment delays (1.40)	388	4.21	.86
12. Complexity of plan's requirements of providers (1.4)	388	4.19	.80
13. Plan's promptness in correction of disputed payments (1.34)	388	4.17	.78
14. Plan's hospital compensation method—disc., per diems, per case, capitation (1.8)	388	4.16	1.01
15. No "most-favored-nation" clause (1.17)	388	4.13	1.08
16. Plan's promptness in responding to authorization requests (1.36)	388	4.11	.86
17. Termination language—balanced and fair (1.16)	388	4.09	.91
18. Payer contracts required by PPOs to discourage silent PPOs (1.15)	388	4.09	.97
19. Fairness of plan's compensation to providers—relative to other plans (1.22)	388	4.09	.84
20. Plan's requirements for authorization of treatment (1.37)	388	4.05	.88

Main survey question number in parentheses

Spearman's rho was calculated to assess the correlation between the responses to the top 20 plan performance factor questions. There were positive correlations between nearly all response pairs, most of which were significant at the .01 level, however, most indicated little or no relationship between the pairs (r = <.25). There were quite a few positive correlations indicating only a fair relationship between the pairs (r = >.25, <.50), most of which were significant at the .01 level,.

The strongest positive and statistically significant correlations were between pairs dealing with payment promptness, payment accuracy, and payment corrections (factors 1.32, 1.11, 1.33, 1.40, and 1.34). The coefficients of correlation for these factor pairs ranged from .505 through .716, all of which were significant at the .01 level. These suggest moderate to good relationships between the factor pairs.

There were other moderate to good relationships between the contract equity and fairness factor (factor 1.14) and balanced contract terms factor (factor 1.10) ($r(387)=.530, p<.01$) and the factors dealing with authorization requirements (factor 1.37) and authorization promptness (factor 1.36) and the factors dealing with payment accuracy (factor 1.33) and prompt payment corrections (factor 1.34). The coefficients of correlation

ranged from .519 through .644 with significance at the .01 level.

The relationship between the respondents' importance scores of the top 20 plan performance factors and the importance scores of plan accreditation and plan ratings was assessed using Spearman's rho. There were statistically significant relationships at the .01 and .05 level between the accreditation and plan ratings importance scores and the importance scores of nearly all of the top 20 plan performance factors. Most of the relationships were weak ($r<.25$) and positive. This means that there was some tendency for the importance scores of the plan accreditation and ratings scores to follow the top 20 plan performance factor scores.

The relationship between the characteristics of the respondents' and the importance scores of the plan performance factors was also assessed using Spearman's rho for bed size and the Mann-Whitney test for urban/rural status and managed care penetration. No remarkable pattern of statistically significant relationships between hospitals' urban/rural status, hospital bed size, or managed care penetration and the importance scores of the plan performance factors was found.

Inclusion of Important Plan Performance Factors in Current Accreditation and Rating Systems

Identifying the source of the top 20 plan performance factors assesses the final research question. This is accomplished by reference back to the tables in Chapter II. Table 74 shows the table reference(s) for each of the top 20 plan performance factors. Table 75 identifies the source of the entries on the tables referenced on Table 74.

Only the 20th most important plan performance factor, plan authorization requirements, is included in one of the commercial accreditation systems or one of the major national rating systems. The factor is included among the factors rated by the MEDSTAT Quality Catalyst Report. While the MEDSTAT Quality Catalyst Report is considered a national report, it focuses its surveys only on selected, large metropolitan areas and is not widely known in the industry.

Table 74

Source of Top 20 Plan Performance Factors

Factor	Source Table
1. Unilateral reductions of bills by plan (1.3)	54
2. Provider problems with plan's compensation (1.5)	54
3. Plan discount levels acceptable (1.13)	1, 43
4. Plan's promptness in provider payments (1.32)	1, 27, 33, 37, 38, 44, 48, 54
5. Requirement for plan payment promptness in contract (1.11)	39, 42, 44, 46
6. Degree of financial risk transfer from plan to providers (1.7)	1
7. Contract terms—balanced or biased to plan (1.10)	1
8. Contract overall equity and fairness (1.14)	1, 38
9. Plan's rate of payment accuracy—percentage of payments right the first time (1.33)	1, 37, 38, 41
10. Amendments by mutual agreement only (1.9)	1, 44, 46, 47

Table 74 (contd.)

11. Plan's average days of claims backlog—degree of payment delays (1.40)	27
12. Complexity of plan's requirements of providers (1.4)	53
13. Plan's promptness in correction of disputed payments (1.34)	37, 38
14. Plan's hospital compensation method—disc., per diems, per case, capitation (1.8)	37, 44, 50, 52
15. No "most-favored-nation" clause (1.17)	1, 45
16. Plan's promptness in responding to authorization requests (1.36)	1, 33, 37, 42, 48, 53
17. Termination language—balanced and fair (1.16)	42, 44, 46
18. Payer contracts required by PPOs to discourage silent PPOs (1.15)	40
19. Fairness of plan's compensation to providers—relative to other plans (1.22)	1, 52
20. Plan's requirements for authorization of treatment (1.37)	1, 8, 44, 52, 53, 54

Main survey question number in parentheses

Table 75

Sources Referenced in Table 74

Table No.	Source
1	Barber, 1997: "Business Partner Rating Factors"
8	Commercial Rating Systems: MEDSTAT, 1997: Quality Catalyst Report
27	Popular Rating Systems: McCafferty, 1997: Trinova Corporation
33	Popular Rating Systems: Diamond and Dalzell, 1998: Indicators of Poor Quality
37	Hospital Surveys: Priest, 1998: NC HFMA Survey
38	Hospital Surveys: 1998 Satisfaction, 1999: Healthcare Association of Southern California Survey
39	Articles: "Advisory Notice," 1995: HFMA
40	Articles: Belt & Ryan, 1998
41	Articles: Shapleigh, 1993
42	Articles: Clark, 1995
43	Articles: Elliott, 1996
44	Articles: Weaver, 1997
45	Articles: Gibbs, 1996
46	Articles: Huff, 1998
47	Articles: Epstein, 1996
48	Legislation: Roslokken, 1999

Table 75 (contd.)

50	Articles: Weinstein and O'Gara, 1992
52	Articles: Anderson, 1997
53	Articles: Smith, 1998
54	Articles: Keister, 1997

C H A P T E R V

DISCUSSION

Overview of Results

The results of the research answer the three research questions posed in Chapter I, fulfill the purpose of the study also presented in Chapter I, and fulfill the objectives of the study identified in Chapter III.

The first research question was to determine how important are accreditation of health plans and the ratings of health plans by the major health plan accreditation and rating systems to acute care general hospitals. The survey results demonstrate that hospitals place only limited value on both the concept of accreditation by a national accrediting organization and actual accreditation by the major health plan accrediting bodies, National Committee for Quality Assurance (NCQA) or Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). This is indicated by the fact that the mean ratings of those questions by the hospital respondents were all 3.0 or less on a scale of 1 to 5. As shown on Table 68, in all cases 60

to 70 percent of the respondents gave either a neutral response (3) or one suggesting that the accreditation was not important (2 or 1).

The responses regarding the importance of the major health plan rating systems followed the same pattern. Only the mean importance scores assigned to a plan's rating by A. M. Best Ratings exceeded 3.0. The ratings assigned under the Health Employer Data Information Set (HEDIS), the Foundation for Accountability (FACCT), and by Weiss Ratings all had mean importance scores of less than 3.0 and all had 60 to 70 percent of respondents assigning a neutral value or one tending toward the not important rating.

The importance scores for plan accreditation and plan ratings are considerably lower than the scores for the nearly all of the plan performance factors. It may be, however, that the scores for plan accreditation and plan ratings are somewhat inflated by their weak but statistically significant correlation with the very high scores assigned to the top 20 plan performance factors. That is, some sort of "halo" effect may have caused the importance of plan accreditation and plan ratings to be overrated. The experience of the author is that plan accreditation and ratings by HEDIS and FACCT are of very little importance in deciding whether a health plan will be a good business partner. The A. M. Best Ratings and Weiss

Ratings are slightly more useful. The Weiss Ratings are the more useful of the two because they rate individually licensed health plans while the A. M. Best Ratings tend to rate the parent company of health plans. It is the performance characteristics of the individual plans that are most important to individual hospitals.

Overall, the results suggest that plan accreditation and plan ratings by the major health plan accrediting and rating systems are not very important to acute care general hospitals in their consideration of participation in managed care health plans.

The respondents' importance scores answer the research question seeking to determine which health plan performance factors are most important to acute care general hospitals. Table 73 lists the 20 plan performance factors receiving the highest mean importance scores. These then are the 20 plan performance factors that are most important to acute care general hospitals.

The final research question is answered in part by the results of the preliminary survey discussed in Chapter III and finally by the results of the analysis of the sources of the top 20 plan performance factors. The preliminary survey indicated that there were 47 plan performance factors that were important to hospitals. The preliminary analysis of the sources of those 47 factors indicated that few of the 47

factors came from the major plan accreditation and rating systems. This result is shown in Table 66, where the factor domains that are most heavily covered by the plan accreditation and rating systems contributed no factors to the list of the most important 47 performance factors.

This question is clearly answered by examination of the sources of the top 20 plan performance factors shown on Table 73. The sources of the top 20 plan performance factors are shown by the combination of tables 74 and 75. Only the 20th most important plan performance factor (question 1.37, requirements for authorization for treatment) came from one of the major plan rating systems, the MEDSTAT Quality Catalyst, as described to the author by letter. As a high cost, proprietary product, it is not widely available and thus is not widely known in the industry. Thus, the answer is clearly "yes," there are plan operational performance factors that are not covered by the existing health plan accreditation and rating systems.

In summary, then, the existing health plan accreditation and health plan rating systems are of no more than modest importance to acute care general hospitals in their contracting decisions. There are health plan performance factors that are important to acute care general hospitals that are not covered by the major health plan accreditation and rating systems. And, this study

identifies the 20 health plan performance factors that are most important to acute care general hospitals, 19 of which are not covered by the existing major health plan accreditation and rating systems.

Discussion

The results of the study support and extend the previous work of the author as reported in Chapter II. Since the factors proposed in the author's previous work (Barber, 1997) were experience-based and not research-based, an academic contact, who shall remain unnamed, dismissed the work as being based on "an expert panel of one." However, 12 of the 15 factors and 3 elements of the those 12 factors proposed by the author ended up among the top 47 factors selected by this study's panel of 19 hospital managed care experts. Eleven of the factors and their elements, as proposed by the author, were among the final top 20 factors in the results of this study. In retrospect, then, the author is now appreciative of the compliment.

In this regard, the results of the study are also consistent with and supportive of the efforts of the North Carolina Healthcare Financial Management Association (Priest, 1998) and the Healthcare Association of Southern California (1998 Satisfaction, 1999). Five of the factors

that Priest attempted to measure in the North Carolina HFMA survey of hospitals were among the top 20 factors resulting from this study. Four of the factors included in the Healthcare Association of Southern California survey of its members are among the top 20 factors in this study.

Insofar as it pertains to acute care general hospitals, the study results also support the contention in the author's previous work that the national accreditation bodies were not providing information that was useful to providers in evaluating managed care plans as business partners (Barber, 1997). The relatively low importance scores (3.0 or less) given to NCQA and JCAHO accreditation of health plans demonstrates that plan accreditation is not very useful to acute care general hospitals in evaluating health plans.

The equally low important scores given to the national rating systems (HEDIS, FACCT, A. M. Best, and Weiss Ratings) demonstrates that the national rating systems do not rate enough of the factors that are important to hospitals. This makes them of little use to hospitals in evaluating health plans as business partners.

None of the factors measured by the national accreditation organizations, NCQA and JCAHO, and none of the factors measured by HEDIS, FACCT, A. M. Best, or Weiss Ratings were among the top 20 factors that are important to

hospitals. This leaves a vacuum of useful information for hospitals to use in evaluating managed care health plans.

The results of the study demonstrate that as far as acute care general hospitals are concerned, the existing definitions and measures of quality miss the mark. This is consistent with the results of the observations of Scanlon, Chernew, Sheffler, and Fendrick (1998) with respect to report cards, showing that hospitals have their own perspective of health plan quality. This is also consistent with the results of Borowsky, Davis, Goertz, and Lurie (1997) who indicated that the perspective of providers is different from that of plan enrollees. Although the observation of Borowsky, et al dealt with the physician perspective of quality, it is no less conceptually applicable to the results of this study. This study also makes it clear that the perspective of managed care health plan quality of acute care general hospitals is also quite different from that of payers, employers, regulators, and most academic researchers on health plan quality.

The results of this study suggest that what is needed is a hospital-oriented definition of health plan quality that is based on those factors that make a plan a good business partner—business partner quality. Like the concept from the Hippocratic Oath that underlies many of the clinical measurements of quality, "First do no harm," one of

the first measures of health plan business partner quality should be that they do no harm. The first 5 of the top 20 factors and 5 others for a total of 50 percent of the top 20 factors all deal with compensation and payments to hospitals. The underlying concept here is that low payments, late payments, and inaccurate payments can do harm to hospitals. Reduced cash flow, additional cost of working capital, and increased administrative cost of dealing with late and inaccurate payments can be very detrimental to the financial health of hospitals. Threats to the financial health of hospitals are ultimately threats to the health of the plans' members. If the hospital cannot fund adequate equipment, supplies and staffing, then the quality of care may be in jeopardy.

Contract terms that are not fair and balanced and put the hospital at a disadvantage are at the heart of another 6 of the top 20 factors. They too can cause financial harm to the hospital and ultimately put the hospital's ability to provide quality care at risk.

Thus, a hospital-oriented definition of the business partner quality of health plans must include those health plan operational factors that have the ability to adversely affect the health of the hospital. That definition of business partner quality must be used to develop standards of health plan performance. The performance of health plans

must be measured and reported in comparison to those standards of performance. Just as the implication of the existing national health plan accreditation and rating systems is that unaccredited and lower rated health plans are less desirable for consumers and payers, so must lower business partner quality ratings imply less desirability to hospitals. The business partner quality ratings must ultimately be used to influence hospitals' willingness to participate with lower rated plans or at least their willingness to offer lower rated plans their best terms.

Limitations

As mentioned in Chapter III, the population from which the sample was drawn was limited to acute care general hospitals. These criteria excluded children's hospitals, rehabilitation hospitals, behavioral care hospitals, and other specialty hospitals from selection. Thus, the results of the study cannot be generalized to hospitals other than acute care general hospitals with statistical validity.

This is really a very minor limitation, however. The reason the other categories of hospitals were excluded was because of their patient mix. Many of the specialty hospitals have a greater mix of patients covered by government programs such as Medicare and Medicaid than do

acute care general hospitals. Accordingly their lower reliance on contracts with commercial managed care health plans might have resulted in a somewhat different response to the survey questions.

In retrospect, given the results of the survey, it is unlikely that the responses of specialty hospitals would have been dramatically different from those of acute care general hospitals. The strongest interests of the hospitals completing the survey were in payment issues. The next strongest interests were in contract fairness, equity, and balance issues. In regard to these issues, the interests of all hospitals are not dramatically dissimilar. Thus, while not statistically valid, the results of this study would probably tend to reflect the interest of the excluded hospitals as well.

With respect to the importance of accreditation and rating systems, the results can only be applied to the six accreditation and rating systems included in the study. There may well be local or regional rating systems that are more important to hospitals in their regions. However, unless an accreditation or rating system is national in scope, it cannot be considered to be broadly important to hospitals.

Recommendations for further study

The professional and popular literature continues to be full of articles regarding physicians' complaints about managed care. Although most of those articles were not considered in this study, it is clear to the author that many of the issues of physicians are the same as those of hospitals. It is also clear to the author that the major accreditation and rating systems do not address the interests of physicians any better than they do those of hospitals. Accordingly, research similar to this study but focused on the interests of physicians would be a useful extension of this study.

The objective of this study was to provide information that will be useful in developing a system of rating health plans from the perspective of hospitals—business partner quality. The study has accomplished its objective. Therefore, the next logical research step toward that end would be to develop a method of rating health plans on the business partner quality factors determined to be important to hospitals. A method of gathering plan specific information from hospitals to use in producing a business partner quality rating of each plan would also need to be developed.

The ultimate follow up research objective would be to

develop a hospital-oriented program of accrediting health plans based on their business partner quality ratings.

Implications for Practice

The primary implications for hospital business practices would involve promoting the development of business partner quality rating systems and/or accreditation systems that focus on the health plan performance factors shown by this study to be important to acute care general hospital. Until such time as national accreditation and rating systems are developed, hospitals and their representative associations can use the results of this study in the conduct of local business partner quality rating surveys. Using the factors identified among the top 20 factors in this study, the hospitals and associations will have assurance that they are measuring performance factors that are in fact important to acute care general hospitals.

Several state and local hospital associations, such as the Healthcare Association of Southern California, currently conduct surveys of their members. Those associations could adopt the factors identified in this survey to ensure that the factors they are surveying are important to their constituents.

It is possible that the results of this study could be used by the national accreditation and rating systems to incorporate the hospital perspective of health plan quality into their ratings and accreditation standards. This is probably unlikely to happen until there is a market imperative. Current accreditation systems are firmly under the control of those representing the payer and clinical perspective. Until a connection can be made between business issues and the payer/clinical perspective of quality, there will not likely be much interest in the results of this study among the existing accreditation systems. Rating systems such as A. M. Best Ratings and Weiss Ratings could very easily add business partner rating factors based on the results of this study to their rating systems. In the case of Weiss Ratings, the addition of these factors would be a very useful addition.

Individual hospitals can use the factors identified in this study to develop measurements of the performance of the health plans with which they currently participate. Those plans having levels of performance significantly lower than average would be targets for performance improvement efforts or termination. Sharing of such business partner quality rating information among hospitals would provide hospitals that are not currently participating with a plan with some information about the performance of the plan as a business

partner. This could be used in negotiations with the plan. Sharing of rating information could also result in some market pressure for improvement in plan performance. If it became known and understood that poorly performing plans had less access to providers or to the best terms from providers, the plans would have market incentive to pay attention to their performance and desirability as hospital business partners.

As a minimum, hospitals should begin demanding terms in contracts that provide for specific performance levels by managed care plans with respect to the performance factors identified in this study. Language providing for measurement and reporting by the plans of their performance in promptness of payment and accuracy of payment, for instance, should be required by the hospitals. This is essential to assure that the plans are aware of and managing their performance. If they are not able to measure their performance, they will not be able to manage their performance.

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APPENDIX A

The Preliminary Survey Instrument

Managed Care Plan Performance Factors Survey

For questions 1 through 12, please indicate how important each factor would be in an ideal situation in influencing your hospital's decision to contract with or continue your participation as a provider in a managed care plan or other health benefit plan.

Please mark your answer based on your initial reaction and sense of relative importance of each factor to the contracting decision.

1. Plan Accreditation and Rating Factors

Factor	Not Important 0	1	2	3	4	Extremely Important 5
1. Plan accreditation by national organization						
2. Plan accreditation by National Committee for Quality Assurance (NCQA)						
3. Plan accreditation by Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)						
4. Plan's Health Employer Data Information Set (HEDIS) ratings						
5. Plan's Foundation for Accountability (FACCT) ratings						
6. Plan's rating by A. M. Best Ratings						
7. Plan's rating by Weiss Ratings, Inc.						

2. Medical Management Performance Rating Factors

Factor	Not Important 0	1	2	3	4	Extremely Important 5
1. Plan's inpatient utilization rates—admissions per thousand members						
2. Plan's rate of high-occurrence/high cost DRGs						
3. Plan's rate of diabetic patient's hospital days per thousand members						
4. Plan's explanation of denials—does the plan explain or just deny						
5. Plan's rate of member prescription compliance						
6. Plan's ratio of hospital days per member						
7. Plan's inpatient average length of stay						
8. Availability of medical director—ability to contact medical director						
9. Plan's utilization review standards used						
10. Plan's utilization review procedures						
11. Plan's medical mgmt. intrusiveness—involvement in patient care decisions						

3. Plan "Hassle" Factors

Factor	Not Important 0	1	2	3	4	Extremely Important 5
1. Member "hassle" factor						
2. System inefficiencies that cause "hassles"						
3. Complexity of plan's requirements of providers						
4. Plan's threats of provider termination						
5. Plan's provider contract terminations						
6. Provider problems with plan's compensation						
7. Unilateral reductions of bills by plan						
8. Plan's excessive requests for patient information						
9. Provider credentialing problems						
10. Plan's use of economic credentialing of providers						
11. Laboratory "carve-out" delays						

Please mark your answer based on your initial reaction and sense of relative importance of each factor to the contracting decision.

4. Organization and Financial Performance Rating Factors

Factor	Not Important 0	1	2	3	4	Extremely Important 5
1. Plan's total membership—covered lives						
2. Plan's enrollment by payer—covered lives by payer						
3. Plan's rate of payer/member disenrollments						
4. Plan's enrollment trends						
5. Plan's enrollment by county/MSA—covered lives by county/MSA						
6. Plan's age/gender enrollment distribution						
7. Plan's average member family size						
8. Plan's physician turnover rate						
9. Plan's years in business						
10. Plan's focus – Long-term or short-term						
11. Indicators of plan's financial stability						
12. Plan's premium rate levels						
13. Plan's premium rate trends						
14. Plan's financial leverage						
15. Plan's operating leverage						
16. Plan's asset leverage						
17. Plan's spread of risk						
18. Plan's reinsurance program						
19. Plan's total assets						
20. Plan's quality of assets						
21. Plan's diversification of assets						
22. Plan's principal investments						
23. Plan's investments in affiliates						
24. Plan's loss reserves						
25. Plan's interest rate risk						
26. Plan's credit risk						
27. Plan's capital structure						
28. Plan's net worth						
29. Plan's risk-adjusted capital						
30. Plan's cash flow						
31. Plan's debt service coverage						
32. Plan's cash and near cash balances						
33. Plan's net income						
34. Plan's investment income						
35. Plan's revenue composition						
36. Quality of plan's management						
37. Plan's industry sector						
38. Plan's lines of business						
39. Plan's market risk						
40. Plan's market share						
41. Plan's event risk						
42. Plan's medical loss ratio—proportion of premium spent on medical services						
43. Plan's administrative loss ratio—proportion of premium spent on administrative						
44. Plan's profit ratio—proportion of premium retained as profit						
45. Plan's cost-effectiveness of care						
46. Plan's per-member-per-month expenses						
47. Plan's ownership status (for-profit or not-for-profit)						
48. Plan's service area						
49. Plan's organization and structure						
50. Plan's network characteristics—providers represented						

Please mark your answer based on your initial reaction and sense of relative importance of each factor to the contracting decision.

5. Contracting Performance Rating Factors

Factor	Not Important 0	1	2	3	4	Extremely Important 5
1. Plan's physician compensation method—fee-for-service. disc.. capitation						
2. Plan's use of physician incentives—bonuses. capitation add-ons						
3. Plan's effectiveness of member education on benefit design and limits						
4. Fairness of plan's compensation to providers—relative to other plans						
5. Degree of financial risk transfer from plan to providers						
6. Contract terms—balanced or biased to plan						
7. Contract overall equity and fairness						
8. Percent of plan's participating primary care physicians paid by capitation						
9. Percent of plan's participating primary care physicians paid by salary						
10. Plan's history of failure to pay bonuses to providers						
11. Identification in contract of services to be provided						
12. Services "carved out" to exclusive specialty providers/networks						
13. Plan's hospital compensation method—disc.. per diems. per case. capitation						
14. Plan's use of exclusive provider contracts						
15. Provider/plan responsibilities clearly defined in contract						
16. Plan's responsiveness to requests for contract changes						
17. Plan's negotiating style						
18. Term of contract—single or multiple year						
19. Requirements for plan data reporting to providers						
20. Requirement for plan payment promptness in contract						
21. Payer contracts required by PPOs to discourage silent PPOs						
22. Plan required to provide notice of addition of new payers to providers						
23. Providers have right to approve/terminate payers						
24. Use of member ID cards with plan logo required						
25. Plan required to communicate benefit limits to providers						
26. Confidentiality of rates to discourage silent PPOs						
27. Plan's usage of patient financial incentives (steerage)						
28. Guarantor clearly identified in contract						
29. Plan use of limited provider network in area						
30. Plan requires payer exclusive geographic use of network						
31. Terms of plan payer agreements described to providers						
32. Definition of emergency care						
33. Definition of medical necessity						
34. Claims submission time limits						
35. Claim documentation requirements						
36. Definition of "clean claim"—to start prompt payment clock						
37. Coordination of benefits language—effect on providers						
38. Stop-loss provisions for providers						
39. Indemnification language—mutual and balanced						
40. Liability insurance requirements consistent with community standard						
41. Termination language—balanced and fair						
42. Assignment provisions—balanced						
43. Plan discount levels acceptable						
44. Plan use of provider incentives						
45. Amendments by mutual agreement only						
46. Confidentiality clause not really a "gag" clause						
47. Non-competition clause reasonable						
48. Arbitration requirements fair						
49. No "most-favored-nation" clause						
50. Access to medical records by plan reasonable						
51. Confidentiality of medical records						
52. Standard of care language acceptable						
53. Continuation of coverage requirements are reasonable						
54. Limitations on retrospective review and denials						
55. No incentive management fees to be paid to plan						

Please mark your answer based on your initial reaction and sense of relative importance of each factor to the contracting decision.

6. Administrative Process Performance Rating Factors

Factor	Not Important 0	1	2	3	4	Extremely Important 5
1. Participating physicians' staff knowledge of plan payment requirements						
2. Participating physician's staff knowledge of referral procedures						
3. Ease of making referrals for plan members						
4. Plan's paperwork requirements for members						
5. Plan members' ability to contact plan						
6. Plan's coordination of benefits procedures						
7. Plan's procedures for handling of out-of-network claims						
8. Plan's appropriateness of premium billing to members/employers						
9. Plan's requirements for authorization of treatment						
10. Plan's procedures for authorization of treatment						
11. Convenience of plan's authorization procedures for providers						
12. Plan's promptness in responding to authorization requests						
13. Plan's appeals process for medical necessity denials						
14. Plan's customer service processes						
15. Plan's account service processes						
16. Plan's decision-making style						
17. Plan's communications processes						
18. Plan's grievance/dispute resolution processes						
19. Plan's information systems—accuracy and usefulness of information						
20. Plan's promptness in provider payments						
21. Plan's average days of claims backlog—degree of payment delays						
22. Plan's rate of payment accuracy—percentage of payments right the first time						
23. Plan's promptness in correction of disputed payments						
24. Plan's promptness in requesting further information needed for payment						
25. Convenience of plan's member eligibility verification process						
26. Plan's promptness in responding to eligibility verification requests						
27. Accuracy of plan's eligibility reports						
28. Responsiveness of provider relations personnel						
29. Average time calls to plan kept on hold—waste of provider staff time						
30. Plan's percent of aborted calls—hang ups from hold						
31. Plan's ratio of member services staff per 1,000 members						
32. Ease of obtaining approval for emergency care for members						
33. Ease of obtaining approval for psychiatric care for members						
34. Ease of obtaining approval for rehabilitative care for members						
35. Plan's services to providers						
36. Degree that necessary information is shown on plan member ID card						
37. Plan communication of employer lists to providers						
38. Ease of filing electronic claims with plan						
39. Ease of obtaining claims status from plan						
40. Ease of identifying patient account on plan payments and correspondence						
41. Ease of identifying payer on plan payments and correspondence						
42. Ease of identifying adjustment amounts on plan payments						
43. Plan provision of appropriate medical record releases						
44. Plan provision of prior notification of on-site reviews						
45. Timeliness of encounter data provided by plan						
46. Accuracy of encounter data provided by plan						
47. Plan's reputation for willingness to resolve issues with providers						
48. Accuracy of plan's provider manuals						
49. Plan's willingness to use standard formats for administrative procedures						

Please mark your answer based on your initial reaction and sense of relative importance of each factor to the contracting decision.

7. Clinical Performance Rating Factors

Factor	Not Important 0	1	2	3	4	Extremely Important 5
1. Plan's rate of beta-blocker treatment after member's heart attack						
2. Plan's rate of eye exams for diabetic patients						
3. Plan's antidepressant medication management						
4. Plan's Cesarean section rate for deliveries						
5. Plan's rate of normal delivery after C-section delivery						
6. Plan's outpatient drug utilization rates						
7. Plan's conservatism in breast surgery						
8. Plan's record of treatment for major depressive disorders						
9. Plan's record in mental health/substance abuse care						
10. Plan's rate of foot exams for diabetic patients						
11. Plan's rate of blood sugar tests for diabetic patients						
12. Plan's disease management programs						
13. Plan's rate of glaucoma testing of members						
14. Plan's degree of implementation of clinical guidelines for utilization mgmt.						
15. Plan's tracking of patient outcomes						
16. Plan's reputation for time physicians spend with patients						
17. Plan's reputation for thoroughness of care						
18. Plan's reputation for continuity of care						
19. Plan's reputation for coordination of care						
20. Post-coronary death rates for plan's participating hospitals						
21. Plan's rate of low-birthweight infants born to members						
22. Plan's rate of prenatal care for members						
23. Plan's pediatric asthma admission rates						
24. Postsurgery complication rates at plan's participating hospitals						
25. Hospital-acquired infection rates at plan's participating hospitals						
26. Plan's rate of heart bypass surgery utilization						
27. Plan's rate of angioplasty procedures utilization						
28. Plan's breast cancer services available to members						

8. Preventive Care Performance Rating Factors

Factor	Not Important 0	1	2	3	4	Extremely Important 5
1. Plan's childhood immunization rates for members						
2. Plan's adolescent immunization rates for members						
3. Plan's utilization rate for smoking cessation programs						
4. Plan's rate of screening mammographies for members						
5. Plan's rate of cervical cancer screening exams for members						
6. Plan's rate of well-child visits for members						
7. Plan's rate of prostrate screening exams for members						
8. Quality of plan's preventive care programs						
9. Plan's cholesterol screening rates for members						
10. Plan's rate of members staying healthy						
11. Plan members' need for preventive services						
12. Percent of plan members visiting PCP in past 3 years						
13. Plan's flu immunization rates for members						

Please mark your answer based on your initial reaction and sense of relative importance of each factor to the contracting decision.

9. Provider Access Rating Factors

Factor	Not Important 0	1	2	3	4	Extremely Important 5
1. Availability of primary care physicians to members						
2. Plan's ratio of members per primary care physician						
3. Percentage of participating practices closed to new patients						
4. Plan's use of primary care physician "gatekeepers"						
5. Availability of pediatricians to members						
6. Availability of geriatricians to members						
7. Availability of major depressive disorder providers to members						
8. Number of physicians participating in plan						
9. Choice of primary care physicians available to members						
10. Member ease of getting appointment with primary care physician						
11. Choice of specialists available to members						
12. Plan's ratio of members per specialty care physician						
13. Member access to specialists						
14. Choice of hospitals available to members						
15. Plan's ration of members per hospital						
16. Member convenience of location of hospitals and ancillaries						
17. Choice of providers available to members						
18. Availability to members of information on participating providers						
19. Member access to care						
20. Member average waiting time for physicians						
21. Member access to physicians by phone						
22. Report rate of members having problems finding physician						
23. Availability of member self-referrals for Ob/Gyn						
24. Member convenience of location of physician offices						
25. Member ease of making physician appointments						
26. Plan's average times per year members visited doctor's office						
27. Plan's average times per year members visited emergency room						
28. Member access to emergency care						
29. Member access to out-of-network emergency care						
30. Member access to out-of-network physicians						
31. Member pharmacy access						
32. Provisions for out-of-area care for members						
33. Plan's restrictions on care						

Please mark your answer based on your initial reaction and sense of relative importance of each factor to the contracting decision.

10. Satisfaction Rating Factors

Factor	Not Important 0	1	2	3	4	Extremely Important 5
1. Member satisfaction with care						
2. Member satisfaction with interpersonal care						
3. Member satisfaction with providers						
4. Member satisfaction with choice of providers						
5. Member overall satisfaction						
6. Member willingness to recommend plan						
7. Member trust in plan						
8. Member satisfaction with primary care physician						
9. Member satisfaction with specialists						
10. Member satisfaction with office staff						
11. Member satisfaction with pharmacy plan						
12. Member satisfaction with customer service						
13. Member intention to re-enroll						
14. Member satisfaction with premium						
15. Member reason for selecting plan						
16. Member out-of-pocket costs						
17. Physician satisfaction with plan						
18. Physician satisfaction with care						
19. Physician willingness to recommend plan						
20. Physician stress/morale						
21. Availability of continuing medical education for physicians						
22. Member complaint ratio						
23. Member satisfaction with courtesy of physicians						
24. Member satisfaction with coverage of plan						
25. Member rating of overall health status						
26. Member satisfaction with physician manner						
27. Member relationship with physician						
28. Member ratings of physician communications						
29. Member ratings of respect given to patients						

11. Coverage Rating Factors

Factor	Not Important 0	1	2	3	4	Extremely Important 5
1. Plan's range of covered services						
2. Plan's benefits to members						
3. Plan's prescription drug benefits						
4. Plan's use of formularies						
5. Flexibility of plan's formulary policies						
6. Plan's home care coverage						
7. Plan's long-term care coverage						
8. Plan's dental coverage						
9. Plan's out-of-network coverage						
10. Plan's mental illness coverage						
11. Plan's preventive care coverage						
12. Plan's emergency care coverage						

Please mark your answer based on your initial reaction and sense of relative importance of each factor to the contracting decision.

12. Provider and Plan Quality Rating Factors

Factor	Not Important 0	1	2	3	4	Extremely Important 5
1. Participating physician board certification rates						
2. Plan's affiliation with physician groups recognized for quality						
3. Participating hospital quality and reputation						
4. Plan's quality improvements record						
5. Quality of participating primary care physicians						
6. Quality of participating specialist physicians						
7. Independent experts' ratings of plan						
8. Plan's reputation for quality of care						
9. Participating physicians' reputation for competence						
10. Overall quality ratings of plan						
11. Malpractice judgements against participating providers						
12. Professional organization disciplinary action rate against participating providers						
13. Participating hospitals' accreditation status						
14. Plan's reporting of quality measures						
15. Plan's performance measurement efforts						
16. Participating physician performance measurement efforts						
17. Plan's medical director qualifications						

13. What other factors are important to you in managed care contracting? _____

_____

_____

14. Is your hospital classified as urban or rural by the Medicare program? _____ Urban _____ Rural

15. Licensed bed size of hospital: _____ beds

16. Does your hospital receive more than 15 percent of its gross revenue from managed care health plans? _____Yes ____No

17. How would you classify your hospital's overall experience with managed care health plans? ____Favorable ___Unfavorable

Thank you for your participation. If you would like a copy of the payment promptness paper or an executive summary of this study, please complete the following: Documents wanted: _____ Prompt payment paper _____ Executive summary

Name: _____ Phone _____ Fax _____

Address: _____ E-mail _____

Address: _____ State _____ Zip _____

APPENDIX B

The Expert Panel Participants

Participant	Geo.	Urban/ Rural	Large Small	High/Low Impact
Michael Trumbore Asst. VP Mgd. Health Resources Carolinas HealthCare System, Charlotte, NC	SE	Urban	Large	High
Ron Szumski, FHFMA Corp. Dir. Contract Admin. Botsford General Hospital Farmington Hills, MI	MW	Urban	Large	High
Robert S. Johnson, CHFP Vice Pres. Managed Care Community Medical Centers Fresno, CA	W	Urban	Large	High
Timothy J. Pollard, FHFMA Sr. Vice President & CFO St. Joseph's Health System Atlanta, GA	SE	Urban	Large	High
Paula L. Greeno, CHFP Director of Managed Care Temple Univ. Health System Philadelphia, PA	NE	Urban	Large	High
Patrick McCabe Norwalk Hospital Norwalk, CT	NE	Urban	Large	High
Lois L. Priest Managed Care Analyst Alamance Reg. Medical Center Burlington, NC	SE	Urban	Large	High
Bertine C. McKenna Medical Center Hospital Burlington, VT	NE	Urban	Large	Low
Nancy K. Linnert-Lehrich Director of Managed Care Cleveland Clinic Foundation Cleveland, OH	MW	Urban	Large	Low
Morgan Hay, FHFMA, CPA Chief Financial Officer Valley Baptist Medical Center Harlingen, TX	SW	Urban	Large	Low
William G. Seck, FHFMA, CPA Chief Financial Officer Adams Co. Memorial Hospital Decatur, IN	MW	Urban	Small	High

Appendix B (contd.)

Sandra M. Roth, CPA Asst. VP Fiscal Affairs Our Lady of Lourdes Med Ctr Camden, NJ	NE	Rural	Large	High
Mason Ellerbe VP, Managed Health Resources Carolinas HealthCare System Charlotte, NC	SE	Rural	Large	High
Anonymous		Rural	Large	Low
Larry J. Marshall, FHFMA Indiana Hospital Indiana, PA	NE	Rural	Small	High
David B. Petrie, FHFMA Sr. Operations Off. & CFO Columbia Memorial Hospital Astoria, OR	NW	Rural	Small	High
James J. Markuson, CHFP Operation Leader Managed Care Valley View Hospital Glenwood Springs, CO	W	Rural	Small	High
John Hodnette, D.H.A., CPA Chief Financial Officer Delta Regional Medical Center Greenville, MS	S	Rural	Small	Low
Bradley P. Smith, CHFP Fisher-Titus Medical Center Norwalk, OH	MW	Rural	Small	Low

Managed Care Plan Performance Factor Survey Results by Domain	Avg	n	Std Devs
1. Plan Acreditation and Rating Factors			
1. 1. Plan accreditation by national organization	3.053	19	
1. 2. Plan accreditation by National Committee for Quality Assurance (NCQA)	3.474	19	
1. 3. Plan accreditation by Joint Comm. on the Accred. of Hlthcare Orgs (JCAHO	2.316	19	
1. 4. Plan's Health Employer Data Information Set (HEDIS) ratings	2.842	19	
1. 5. Plan's Foundation for Accountability (FACCT) ratings	1.842	19	
1. 6. Plan's rating by A. M. Best Ratings	2.632	19	
1. 7. Plan's rating by Weiss Ratings, Inc.	2.368	19	
2. Medical Management Performance Rating Factors			
2. 1. Plan's inpatient utilization rates-admissions per thousand members	2.895	19	-0.584
2. 2. Plan's rate of high-occurrence/high cost DRGs	3.000	19	-0.423
2. 3. Plan's rate of diabetic patient's hospital days per thousand members	2.167	18	-1.697
2. 4. Plan's explanation of denials-does the plan explain or just deny	4.000	19	1.105
2. 5. Plan's rate of member prescription compliance	2.222	18	-1.612
2. 6. Plan's ratio of hospital days per member	2.789	19	-0.745
2. 7. Plan's inpatient average length of stay	3.211	19	-0.102
2. 8. Availability of medical director-ability to contact medical director	3.444	18	0.256
2. 9. Plan's utilization review standards used	3.947	19	1.025
2.10. Plan's utilization review procedures	4.158	19	1.346
2.11. Plan's medical mgmt. intrusiveness-involvement in patient care decisions	***4.158***	19	1.346
3. Plan "Hassle" Factors			
3. 1. Member "hassle" factor	2.722	18	-0.848
3. 2. System inefficiencies that cause "hassles"	3.667	18	0.596
3. 3. Complexity of plan's requirements of providers	4.421	19	1.749
3. 4. Plan's threats of provider termination	3.368	19	0.140
3. 5. Plan's provider contract terminations	3.556	18	0.426
3. 6. Provider problems with plan's compensation	4.316	19	1.588
3. 7. Unilateral reductions of bills by plan	4.474	19	1.829
3. 8. Plan's excessive requests for patient information	4.105	19	1.266

Managed Care Plan Performance Factor Survey Results by Domain	Avg	n	Std Devs
3. 9. Provider credentialing problems	3.947	19	1.025
3. 10. Plan's use of economic credentialing of providers	3.647	17	0.566
3. 11. Laboratory "carve-out" delays	3.500	18	0.341
4. Organization and Financial Performance Rating Factors			
4. 1. Plan's total membership-covered lives	4.000	19	1.105
4. 2. Plan's enrollment by payer-covered lives by payer	3.474	19	0.301
4. 3. Plan's rate of payer/member disenrollments	3.000	19	-0.423
4. 4. Plan's enrollment trends	3.500	18	0.341
4. 5. Plan's enrollment by county/MSA-covered lives by county/MSA	3.316	19	0.059
4. 6. Plan's age/gender enrollment distribution	2.895	19	-0.584
4. 7. Plan's average member family size	2.111	18	-1.782
4. 8. Plan's physician turnover rate	2.667	18	-0.933
4. 9. Plan's years in business	3.316	19	0.059
4. 10. Plan's focus -- Long-term or short-term	3.368	19	0.140
4. 11. Indicators of plan's financial stability	4.263	19	1.507
4. 12. Plan's premium rate levels	3.158	19	-0.182
4. 13. Plan's premium rate trends	3.333	18	0.086
4. 14. Plan's financial leverage	3.222	18	-0.084
4. 15. Plan's operating leverage	3.167	18	-0.169
4. 16. Plan's asset leverage	3.056	18	-0.339
4. 17. Plan's spread of risk	3.111	18	-0.254
4. 18. Plan's reinsurance program	3.167	18	-0.169
4. 19. Plan's total assets	2.944	18	-0.508
4. 20. Plan's quality of assets	2.778	18	-0.763
4. 21. Plan's diversification of assets	2.611	18	-1.018
4. 22. Plan's principal investments	2.278	18	-1.527
4. 23. Plan's investments in affiliates	2.333	18	-1.442
4. 24. Plan's loss reserves	3.389	18	0.171
4. 25. Plan's interest rate risk	2.278	18	-1.527
4. 26. Plan's credit risk	2.333	18	-1.442
4. 27. Plan's capital structure	2.556	18	-1.103

Managed Care Plan Performance Factor Survey Results by Domain	Avg	n	Std Devs
4. 28. Plan's net worth	2.944	18	-0.508
4. 29. Plan's risk-adjusted capital	2.722	18	-0.848
4. 30. Plan's cash flow	3.222	18	-0.084
4. 31. Plan's debt service coverage	2.722	18	-0.848
4. 32. Plan's cash and near cash balances	3.056	18	-0.339
4. 33. Plan's net income	3.167	18	-0.169
4. 34. Plan's investment income	2.444	18	-1.273
4. 35. Plan's revenue composition	2.667	18	-0.933
4. 36. Quality of plan's management	3.722	18	0.680
4. 37. Plan's industry sector	2.833	18	-0.678
4. 38. Plan's lines of business	3.111	18	-0.254
4. 39. Plan's market risk	2.833	18	-0.678
4. 40. Plan's market share	3.895	19	0.944
4. 41. Plan's event risk	2.444	18	-1.273
4. 42. Plan's medical loss ratio-proportion of premium spent on medical services	***3.842***	19	0.864
4. 43. Plan's administrative loss ratio-proportion of premium spent on administrati	3.789	19	0.783
4. 44. Plan's profit ratio-proportion of premium retained as profit	3.389	18	0.171
4. 45. Plan's cost-effectiveness of care	3.211	19	-0.102
4. 46. Plan's per-member-per-month expenses	3.368	19	0.140
4. 47. Plan's ownership status (for-profit or not-for-profit)	2.611	18	-1.018
4. 48. Plan's service area	3.789	19	0.783
4. 49. Plan's organization and structure	2.895	19	-0.584
4. 50. Plan's network characteristics-providers represented	3.632	19	0.542
5. Contracting Performance Rating Factors			
5. 1. Plan's physician compensation method-fee-for-service, disc., capitation	4.316	19	1.588
5. 2. Plan's use of physician incentives-bonuses, capitation add-ons	4.158	19	1.346
5. 3. Plan's effectiveness of member education on benefit design and limits	***3.526***	19	0.381
5. 4. Fairness of plan's compensation to providers-relative to other plans	4.211	19	1.427
5. 5. Degree of financial risk transfer from plan to providers	***4.684***	19	2.151
5. 6. Contract terms-balanced or biased to plan	***4.526***	19	1.910

Managed Care Plan Performance Factor Survey Results by Domain	Avg	n	Std Devs
5. 7. Contract overall equity and fairness	***4.421***	19	1.749
5. 8. Percent of plan's participating primary care physicians paid by capitation	2.778	18	-0.763
5. 9. Percent of plan's participating primary care physicians paid by salary	2.389	18	-1.358
5. 10. Plan's history of failure to pay bonuses to providers	3.500	18	0.341
5. 11. Identification in contract of services to be provided	4.105	19	1.266
5. 12. Services "carved out" to exclusive specialty providers/networks	3.947	19	1.025
5. 13. Plan's hospital compensation method-disc., per diems, per case, capitation	4.632	19	2.070
5. 14. Plan's use of exclusive provider contracts	4.421	19	1.749
5. 15. Provider/plan responsibilities clearly defined in contract	4.158	19	1.346
5. 16. Plan's responsiveness to requests for contract changes	4.000	19	1.105
5. 17. Plan's negotiating style	3.789	19	0.783
5. 18. Term of contract-single or multiple year	4.000	19	1.105
5. 19. Requirements for plan data reporting to providers	3.947	19	1.025
5. 20. Requirement for plan payment promptness in contract	4.474	19	1.829
5. 21. Payer contracts required by PPOs to discourage silent PPOs	4.389	18	1.700
5. 22. Plan required to provide notice of addition of new payers to providers	3.833	18	0.850
5. 23. Providers have right to approve/terminate payers	3.667	18	0.596
5. 24. Use of member ID cards with plan logo required	4.158	19	1.346
5. 25. Plan required to communicate benefit limits to providers	3.947	19	1.025
5. 26. Confidentiality of rates to discourage silent PPOs	4.263	19	1.507
5. 27. Plan's usage of patient financial incentives (steerage)	4.263	19	1.507
5. 28. Guarantor clearly identified in contract	3.737	19	0.703
5. 29. Plan use of limited provider network in area	3.789	19	0.783
5. 30. Plan requires payer exclusive geographic use of network	3.737	19	0.703
5. 31. Terms of plan payer agreements described to providers	3.556	18	0.426
5. 32. Definition of emergency care	4.000	19	1.105
5. 33. Definition of medical necessity	4.105	19	1.266
5. 34. Claims submission time limits	3.842	19	0.864
5. 35. Claim documentation requirements	3.842	19	0.864
5. 36. Definition of "clean claim"-to start prompt payment clock	4.263	19	1.507
5. 37. Coordination of benefits language-effect on providers	3.737	19	0.703
5. 38. Stop-loss provisions for providers	3.895	19	0.944
5. 39. Indemnification language-mutual and balanced	***3.947***	19	1.025

Managed Care Plan Performance Factor Survey Results by Domain	Avg	n	Std Devs
5.40. Liability insurance requirements consistent with community standard	3.842	19	0.864
5.41. Termination language-balanced and fair	***4.316***	19	1.588
5.42. Assignment provisions-balanced	4.000	19	1.105
5.43. Plan discount levels acceptable	4.421	19	1.749
5.44. Plan use of provider incentives	3.947	19	1.025
5.45. Amendments by mutual agreement only	***4.632***	19	2.070
5.46. Confidentiality clause not really a "gag" clause	4.053	19	1.186
5.47. Non-competition clause reasonable	3.842	19	0.864
5.48. Arbitration requirements fair	4.053	19	1.186
5.49. No "most-favored-nation" clause	4.316	19	1.588
5.50. Access to medical records by plan reasonable	4.000	19	1.105
5.51. Confidentiality of medical records	4.000	19	1.105
5.52. Standard of care language acceptable	3.842	19	0.864
5.53. Continuation of coverage requirements are reasonable	3.842	19	0.864
5.54. Limitations on retrospective review and denials	4.158	19	1.346
5.55. No incentive management fees to be paid to plan	3.750	16	0.723
6. Administrative Process Performance Rating Factors			
6. 1. Participating physicians' staff knowledge of plan payment requirements	3.789	19	0.783
6. 2. Participating physician's staff knowledge of referral procedures	4.105	19	1.266
6. 3. Ease of making referrals for plan members	3.947	19	1.025
6. 4. Plan's paperwork requirements for members	3.056	18	-0.339
6. 5. Plan members' ability to contact plan	3.278	18	0.001
6. 6. Plan's coordination of benefits procedures	3.737	19	0.703
6. 7. Plan's procedures for handling of out-of-network claims	3.368	19	0.140
6. 8. Plan's appropriateness of premium billing to members/employers	2.222	18	-1.612
6. 9. Plan's requirements for authorization of treatment	4.211	19	1.427
6.10. Plan's procedures for authorization of treatment	4.158	19	1.346
6.11. Convenience of plan's authorization procedures for providers	***4.158***	19	1.346
6.12. Plan's promptness in responding to authorization requests	***4.263***	19	1.507
6.13. Plan's appeals process for medical necessity denials	4.105	19	1.266
6.14. Plan's customer service processes	3.421	19	0.220

Managed Care Plan Performance Factor Survey Results by Domain	Avg	n	Std Devs
6.15. Plan's account service processes	3.556	18	0.426
6.16. Plan's decision-making style	3.316	19	0.059
6.17. Plan's communications processes	3.579	19	0.461
6.18. Plan's grievance/dispute resolution processes	3.947	19	1.025
6.19. Plan's information systems-accuracy and usefulness of information	4.000	19	1.105
6.20. Plan's promptness in provider payments	***4.526***	19	1.910
6.21. Plan's average days of claims backlog-degree of payment delays	4.158	19	1.346
6.22. Plan's rate of payment accuracy-percentage of payments right the first time	***4.421***	19	1.749
6.23. Plan's promptness in correction of disputed payments	4.368	19	1.668
6.24. Plan's promptness in requesting further information needed for payment	4.211	19	1.427
6.25. Convenience of plan's member eligibility verification process	***4.211***	19	1.427
6.26. Plan's promptness in responding to eligibility verification requests	***4.105***	19	1.266
6.27. Accuracy of plan's eligibility reports	4.105	19	1.266
6.28. Responsiveness of provider relations personnel	***3.895***	19	0.944
6.29. Average time calls to plan kept on hold-waste of provider staff time	3.895	19	0.944
6.30. Plan's percent of aborted calls-hang ups from hold	3.316	19	0.059
6.31. Plan's ratio of member services staff per 1,000 members	2.833	18	-0.678
6.32. Ease of obtaining approval for emergency care for members	3.895	19	0.944
6.33. Ease of obtaining approval for psychiatric care for members	3.316	19	0.059
6.34. Ease of obtaining approval for rehabilitative care for members	3.474	19	0.301
6.35. Plan's services to providers	3.421	19	0.220
6.36. Degree that necessary information is shown on plan member ID card	4.263	19	1.507
6.37. Plan communication of employer lists to providers	3.474	19	0.301
6.38. Ease of filing electronic claims with plan	4.158	19	1.346
6.39. Ease of obtaining claims status from plan	3.947	19	1.025
6.40. Ease of identifying patient account on plan payments and correspondence	3.895	19	0.944
6.41. Ease of identifying payer on plan payments and correspondence	3.842	19	0.864
6.42. Ease of identifying adjustment amounts on plan payments	3.895	19	0.944
6.43. Plan provision of appropriate medical record releases	3.526	19	0.381
6.44. Plan provision of prior notification of on-site reviews	3.632	19	0.542
6.45. Timeliness of encounter data provided by plan	3.316	19	0.059
6.46. Accuracy of encounter data provided by plan	3.421	19	0.220
6.47. Plan's reputation for willingness to resolve issues with providers	4.000	19	1.105

Managed Care Plan Performance Factor Survey Results by Domain	Avg	n	Std Devs
6. 48. Accuracy of plan's provider manuals	3.842	19	0.864
6. 49. Plan's willingness to use standard formats for administrative procedures	3.947	19	1.025
7. Clinical Performance Rating Factors			
7. 1. Plan's rate of beta-blocker treatment after member's heart attack	2.500	18	-1.188
7. 2. Plan's rate of eye exams for diabetic patients	2.389	18	-1.358
7. 3. Plan's antidepressant medication management	2.278	18	-1.527
7. 4. Plan's Cesarean section rate for deliveries	2.556	18	-1.103
7. 5. Plan's rate of normal delivery after C-section delivery	2.389	18	-1.358
7. 6. Plan's outpatient drug utilization rates	2.556	18	-1.103
7. 7. Plan's conservatism in breast surgery	2.278	18	-1.527
7. 8. Plan's record of treatment for major depressive disorders	2.278	18	-1.527
7. 9. Plan's record in mental health/substance abuse care	2.444	18	-1.273
7. 10. Plan's rate of foot exams for diabetic patients	2.389	18	-1.358
7. 11. Plan's rate of blood sugar tests for diabetic patients	2.333	18	-1.442
7. 12. Plan's disease management programs	2.944	18	-0.508
7. 13. Plan's rate of glaucoma testing of members	2.333	18	-1.442
7. 14. Plan's degree of implementation of clinical guidelines for utilization mgmt.	3.500	18	0.341
7. 15. Plan's tracking of patient outcomes	2.778	18	-0.763
7. 16. Plan's reputation for time physicians spend with patients	2.500	18	-1.188
7. 17. Plan's reputation for thoroughness of care	2.947	19	-0.504
7. 18. Plan's reputation for continuity of care	3.105	19	-0.263
7. 19. Plan's reputation for coordination of care	3.158	19	-0.182
7. 20. Post-coronary death rates for plan's participating hospitals	2.389	18	-1.358
7. 21. Plan's rate of low-birthweight infants born to members	2.333	18	-1.442
7. 22. Plan's rate of prenatal care for members	2.556	18	-1.103
7. 23. Plan's pediatric asthma admission rates	2.444	18	-1.273
7. 24. Postsurgery complication rates at plan's participating hospitals	2.611	18	-1.018
7. 25. Hospital-acquired infection rates at plan's participating hospitals	2.611	18	-1.018
7. 26. Plan's rate of heart bypass surgery utilization	2.500	18	-1.188
7. 27. Plan's rate of angioplasty procedures utilization	2.500	18	-1.188
7. 28. Plan's breast cancer services available to members	2.667	18	-0.933

Managed Care Plan Performance Factor Survey Results by Domain	Avg	n	Std Devs
8. Preventive Care Performance Rating Factors			
8. 1. Plan's childhood immunization rates for members	2.500	18	-1.188
8. 2. Plan's adolescent immunization rates for members	2.444	18	-1.273
8. 3. Plan's utilization rate for smoking cessation programs	2.278	18	-1.527
8. 4. Plan's rate of screening mammographies for members	2.667	18	-0.933
8. 5. Plan's rate of cervical cancer screening exams for members	2.444	18	-1.273
8. 6. Plan's rate of well-child visits for members	2.500	18	-1.188
8. 7. Plan's rate of prostrate screening exams for members	2.500	18	-1.188
8. 8. Quality of plan's preventive care programs	2.684	19	-0.906
8. 9. Plan's cholesterol screening rates for members	2.444	18	-1.273
8. 10. Plan's rate of members staying healthy	2.389	18	-1.358
8. 11. Plan members' need for preventive services	2.389	18	-1.358
8. 12. Percent of plan members visiting PCP in past 3 years	2.526	19	-1.148
8. 13. Plan's flu immunization rates for members	2.167	18	-1.697
9. Provider Access Rating Factors			
9. 1. Availability of primary care physicians to members	3.588	17	0.476
9. 2. Plan's ratio of members per primary care physician	3.167	18	-0.169
9. 3. Percentage of participating practices closed to new patients	2.882	17	-0.603
9. 4. Plan's use of primary care physician "gatekeepers"	3.333	18	0.086
9. 5. Availability of pediatricians to members	2.882	17	-0.603
9. 6. Availability of geriatricians to members	2.235	17	-1.592
9. 7. Availability of major depressive disorder providers to members	2.353	17	-1.413
9. 8. Number of physicians participating in plan	3.059	17	-0.334
9. 9. Choice of primary care physicians available to members	3.294	17	0.026
9. 10. Member ease of getting appointment with primary care physician	3.118	17	-0.244
9. 11. Choice of specialists available to members	3.235	17	-0.064
9. 12. Plan's ratio of members per specialty care physician	2.556	18	-1.103
9. 13. Member access to specialists	3.000	17	-0.423
9. 14. Choice of hospitals available to members	3.611	18	0.511

Managed Care Plan Performance Factor Survey Results by Domain	Avg	n	Std Devs
9. 15. Plan's ration of members per hospital	2.294	17	-1.502
9. 16. Member convenience of location of hospitals and ancillaries	3.118	17	-0.244
9. 17. Choice of providers available to members	3.389	18	0.171
9. 18. Availability to members of information on participating providers	3.278	18	0.001
9. 19. Member access to care	3.529	17	0.386
9. 20. Member average waiting time for physicians	2.706	17	-0.873
9. 21. Member access to physicians by phone	2.588	17	-1.053
9. 22. Report rate of members having problems finding physician	2.824	17	-0.693
9. 23. Availability of member self-referrals for Ob/Gyn	2.824	17	-0.693
9. 24. Member convenience of location of physician offices	3.235	17	-0.064
9. 25. Member ease of making physician appointments	2.824	17	-0.693
9. 26. Plan's average times per year members visited doctor's office	2.722	18	-0.848
9. 27. Plan's average times per year members visited emergency room	3.000	18	-0.423
9. 28. Member access to emergency care	3.235	17	-0.064
9. 29. Member access to out-of-network emergency care	2.882	17	-0.603
9. 30. Member access to out-of-network physicians	2.824	17	-0.693
9. 31. Member pharmacy access	2.647	17	-0.963
9. 32. Provisions for out-of-area care for members	3.235	17	-0.064
9. 33. Plan's restrictions on care	3.765	17	0.745
10. Satisfaction Rating Factors			
10. 1. Member satisfaction with care	3.059	17	-0.334
10. 2. Member satisfaction with interpersonal care	2.438	16	-1.283
10. 3. Member satisfaction with providers	3.235	17	-0.064
10. 4. Member satisfaction with choice of providers	3.235	17	-0.064
10. 5. Member overall satisfaction	3.059	17	-0.334
10. 6. Member willingness to recommend plan	2.882	17	-0.603
10. 7. Member trust in plan	2.647	17	-0.963
10. 8. Member satisfaction with primary care physician	2.882	17	-0.603
10. 9. Member satisfaction with specialists	2.706	17	-0.873
10. 10. Member satisfaction with office staff	2.706	17	-0.873
10. 11. Member satisfaction with pharmacy plan	2.353	17	-1.413

Managed Care Plan Performance Factor Survey Results by Domain	Avg	n	Std Devs
10. 12. Member satisfaction with customer service	2.706	17	-0.873
10. 13. Member intention to re-enroll	3.056	18	-0.339
10. 14. Member satisfaction with premium	2.353	17	-1.413
10. 15. Member reason for selecting plan	2.118	17	-1.772
10. 16. Member out-of-pocket costs	3.000	17	-0.423
10. 17. Physician satisfaction with plan	3.389	18	0.171
10. 18. Physician satisfaction with care	3.444	18	0.256
10. 19. Physician willingness to recommend plan	2.882	17	-0.603
10. 20. Physician stress/morale	2.875	16	-0.615
10. 21. Availability of continuing medical education for physicians	2.294	17	-1.502
10. 22. Member complaint ratio	***2.765***	17	-0.783
10. 23. Member satisfaction with courtesy of physicians	2.765	17	-0.783
10. 24. Member satisfaction with coverage of plan	2.824	17	-0.693
10. 25. Member rating of overall health status	2.588	17	-1.053
10. 26. Member satisfaction with physician manner	2.647	17	-0.963
10. 27. Member relationship with physician	2.647	17	-0.963
10. 28. Member ratings of physician communications	2.647	17	-0.963
10. 29. Member ratings of respect given to patients	2.765	17	-0.783
11. Coverage Rating Factors			
11. 1. Plan's range of covered services	3.722	18	0.680
11. 2. Plan's benefits to members	3.333	18	0.086
11. 3. Plan's prescription drug benefits	2.611	18	-1.018
11. 4. Plan's use of formularies	2.889	18	-0.593
11. 5. Flexibility of plan's formulary policies	2.833	18	-0.678
11. 6. Plan's home care coverage	3.222	18	-0.084
11. 7. Plan's long-term care coverage	2.889	18	-0.593
11. 8. Plan's dental coverage	2.111	18	-1.782
11. 9. Plan's out-of-network coverage	2.889	18	-0.593
11. 10. Plan's mental illness coverage	2.944	18	-0.508
11. 11. Plan's preventive care coverage	3.000	18	-0.423
11. 12. Plan's emergency care coverage	3.556	18	0.426

Managed Care Plan Performance Factor Survey Results by Domain	Avg	n	Std Devs
12. Provider and Plan Quality Rating Factors			
12. 1. Participating physician board certification rates	3.235	17	-0.064
12. 2. Plan's affiliation with physician groups recognized for quality	3.278	18	0.001
12. 3. Participating hospital quality and reputation	3.833	18	0.850
12. 4. Plan's quality improvements record	3.111	18	-0.254
12. 5. Quality of participating primary care physicians	3.667	18	0.596
12. 6. Quality of participating specialist physicians	3.667	18	0.596
12. 7. Independent experts' ratings of plan	3.222	18	-0.084
12. 8. Plan's reputation for quality of care	3.556	18	0.426
12. 9. Participating physicians' reputation for competence	3.167	18	-0.169
12. 10. Overall quality ratings of plan	3.588	17	0.476
12. 11. Malpractice judgements against participating providers	2.706	17	-0.873
12. 12. Professional organization disciplinary action rate against participating provid	2.941	17	-0.513
12. 13. Participating hospitals' accreditation status	3.294	17	0.026
12. 14. Plan's reporting of quality measures	3.353	17	0.116
12. 15. Plan's performance measurement efforts	3.176	17	-0.154
12. 16. Participating physician performance measurement efforts	3.176	17	-0.154
12. 17. Plan's medical director qualifications	3.235	17	-0.064
Mean	3.277		
Standard Deviation	0.654		
13 What other factors are important to you in managed care contracting?			
14 Is your hospital classified as urban or rural by the Medicare program?		18	
15 Licensed bed size of hospital:	9377	18	
16 More than 15 percent of its gross revenue from managed care health plans?		18	

	Managed Care Plan Performance Factor Survey Results by Domain	Avg	n	Std Devs
17	Would you classify your overall experience with managed care health plans?	0.529	17	

Summary

1. Plan Acreditation and Rating Factors	2.647
2. Medical Management Performance Rating Factors	3.272
3. Plan "Hassle" Factors	3.793
4. Organization and Financial Performance Rating Factors	3.079
5. Contracting Performance Rating Factors	3.999
6. Administrative Process Performance Rating Factors	3.786
7. Clinical Performance Rating Factors	2.581
8. Preventive Care Performance Rating Factors	2.456
9. Provider Access Rating Factors	3.007
10. Satisfaction Rating Factors	2.792
11. Coverage Rating Factors	3.000
12. Provider and Plan Quality Rating Factors	3.306

Managed Care Plan Performance Factor Survey Results by Std. Deviations	Avg	n	Std Devs
5. 5. Degree of financial risk transfer from plan to providers	***4.684***	19	2.151
5.13. Plan's hospital compensation method-disc., per diems, per case, capitation	4.632	19	2.070
5.45. Amendments by mutual agreement only	***4.632***	19	2.070
5. 6. Contract terms-balanced or biased to plan	***4.526***	19	1.910
6.20. Plan's promptness in provider payments	***4.526***	19	1.910
3. 7. Unilateral reductions of bills by plan	4.474	19	1.829
5.20. Requirement for plan payment promptness in contract	4.474	19	1.829
5.14. Plan's use of exclusive provider contracts	4.421	19	1.749
5.43. Plan discount levels acceptable	4.421	19	1.749
6.22. Plan's rate of payment accuracy-percentage of payments right the first time	***4.421***	19	1.749
3. 3. Complexity of plan's requirements of providers	4.421	19	1.749
5. 7. Contract overall equity and fairness	***4.421***	19	1.749
5.21. Payer contracts required by PPOs to discourage silent PPOs	4.389	18	1.700
6.23. Plan's promptness in correction of disputed payments	4.368	19	1.668
5.41. Termination language-balanced and fair	***4.316***	19	1.588
5.49. No "most-favored-nation" clause	4.316	19	1.588
5. 1. Plan's physician compensation method-fee-for-service, disc., capitation	4.316	19	1.588
3. 6. Provider problems with plan's compensation	4.316	19	1.588
4.11. Indicators of plan's financial stability	4.263	19	1.507
6.36. Degree that necessary information is shown on plan member ID card	4.263	19	1.507
5.27. Plan's usage of patient financial incentives (steerage)	4.263	19	1.507
5.36. Definition of "clean claim"-to start prompt payment clock	4.263	19	1.507
5.26. Confidentiality of rates to discourage silent PPOs	4.263	19	1.507
6.12. Plan's promptness in responding to authorization requests	***4.263***	19	1.507
5. 4. Fairness of plan's compensation to providers-relative to other plans	4.211	19	1.427
6. 9. Plan's requirements for authorization of treatment	4.211	19	1.427
6.25. Convenience of plan's member eligibility verification process	***4.211***	19	1.427
6.24. Plan's promptness in requesting further information needed for payment	4.211	19	1.427
6.21. Plan's average days of claims backlog-degree of payment delays	4.158	19	1.346
6.11. Convenience of plan's authorization procedures for providers	***4.158***	19	1.346
6.10. Plan's procedures for authorization of treatment	4.158	19	1.346
2.11. Plan's medical mgmt. intrusiveness-involvement in patient care decisions	***4.158***	19	1.346

Managed Care Plan Performance Factor Survey Results by Std. Deviations	Avg	n	Std Devs
5. 15. Provider/plan responsibilities clearly defined in contract	4.158	19	1.346
6. 38. Ease of filing electronic claims with plan	4.158	19	1.346
5. 24. Use of member ID cards with plan logo required	4.158	19	1.346
5. 2. Plan's use of physician incentives-bonuses, capitation add-ons	4.158	19	1.346
2. 10. Plan's utilization review procedures	4.158	19	1.346
5. 54. Limitations on retrospective review and denials	4.158	19	1.346
6. 13. Plan's appeals process for medical necessity denials	4.105	19	1.266
3. 8. Plan's excessive requests for patient information	4.105	19	1.266
6. 27. Accuracy of plan's eligibility reports	4.105	19	1.266
6. 2. Participating physician's staff knowledge of referral procedures	4.105	19	1.266
5. 11. Identification in contract of services to be provided	4.105	19	1.266
5. 33. Definition of medical necessity	4.105	19	1.266
6. 26. Plan's promptness in responding to eligibility verification requests	***4.105***	19	1.266
5. 46. Confidentiality clause not really a "gag" clause	4.053	19	1.186
5. 48. Arbitration requirements fair	4.053	19	1.186
5. 42. Assignment provisions-balanced	4.000	19	1.105
5. 51. Confidentiality of medical records	4.000	19	1.105
5. 50. Access to medical records by plan reasonable	4.000	19	1.105
5. 32. Definition of emergency care	4.000	19	1.105
4. 1. Plan's total membership-covered lives	4.000	19	1.105
2. 4. Plan's explanation of denials-does the plan explain or just deny	4.000	19	1.105
5. 18. Term of contract-single or multiple year	4.000	19	1.105
6. 19. Plan's information systems-accuracy and usefulness of information	4.000	19	1.105
5. 16. Plan's responsiveness to requests for contract changes	4.000	19	1.105
6. 47. Plan's reputation for willingness to resolve issues with providers	4.000	19	1.105
3. 9. Provider credentialing problems	3.947	19	1.025
6. 18. Plan's grievance/dispute resolution processes	3.947	19	1.025
6. 49. Plan's willingness to use standard formats for administrative procedures	3.947	19	1.025
5. 25. Plan required to communicate benefit limits to providers	3.947	19	1.025
5. 19. Requirements for plan data reporting to providers	3.947	19	1.025
5. 44. Plan use of provider incentives	3.947	19	1.025
5. 12. Services "carved out" to exclusive specialty providers/networks	3.947	19	1.025
6. 39. Ease of obtaining claims status from plan	3.947	19	1.025

Managed Care Plan Performance Factor Survey Results by Std. Deviations	Avg	n	Std Devs
5. 39. Indemnification language-mutual and balanced	***3.947***	19	1.025
2. 9. Plan's utilization review standards used	3.947	19	1.025
6. 3. Ease of making referrals for plan members	3.947	19	1.025
5. 38. Stop-loss provisions for providers	3.895	19	0.944
6. 42. Ease of identifying adjustment amounts on plan payments	3.895	19	0.944
4. 40. Plan's market share	3.895	19	0.944
6. 29. Average time calls to plan kept on hold-waste of provider staff time	3.895	19	0.944
6. 28. Responsiveness of provider relations personnel	***3.895***	19	0.944
6. 32. Ease of obtaining approval for emergency care for members	3.895	19	0.944
6. 40. Ease of identifying patient account on plan payments and correspondence	3.895	19	0.944
5. 52. Standard of care language acceptable	3.842	19	0.864
5. 34. Claims submission time limits	3.842	19	0.864
5. 35. Claim documentation requirements	3.842	19	0.864
5. 40. Liability insurance requirements consistent with community standard	3.842	19	0.864
6. 41. Ease of identifying payer on plan payments and correspondence	3.842	19	0.864
5. 47. Non-competition clause reasonable	3.842	19	0.864
5. 53. Continuation of coverage requirements are reasonable	3.842	19	0.864
6. 48. Accuracy of plan's provider manuals	3.842	19	0.864
4. 42. Plan's medical loss ratio-proportion of premium spent on medical services	***3.842***	19	0.864
12. 3. Participating hospital quality and reputation	3.833	18	0.850
5. 22. Plan required to provide notice of addition of new payers to providers	3.833	18	0.850
5. 29. Plan use of limited provider network in area	3.789	19	0.783
5. 17. Plan's negotiating style	3.789	19	0.783
4. 48. Plan's service area	3.789	19	0.783
6. 1. Participating physicians' staff knowledge of plan payment requirements	3.789	19	0.783
4. 43. Plan's administrative loss ratio-proportion of premium spent on administrati	3.789	19	0.783
9. 33. Plan's restrictions on care	3.765	17	0.745
5. 55. No incentive management fees to be paid to plan	3.750	16	0.723
5. 28. Guarantor clearly identified in contract	3.737	19	0.703
6. 6. Plan's coordination of benefits procedures	3.737	19	0.703
5. 37. Coordination of benefits language-effect on providers	3.737	19	0.703
5. 30. Plan requires payer exclusive geographic use of network	3.737	19	0.703
11. 1. Plan's range of covered services	3.722	18	0.680

Managed Care Plan Performance Factor Survey Results by Std. Deviations	Avg	n	Std Devs
4. 36. Quality of plan's management	3.722	18	0.680
12. 5. Quality of participating primary care physicians	3.667	18	0.596
12. 6. Quality of participating specialist physicians	3.667	18	0.596
3. 2. System inefficiencies that cause "hassles"	3.667	18	0.596
5. 23. Providers have right to approve/terminate payers	3.667	18	0.596
3. 10. Plan's use of economic credentialing of providers	3.647	17	0.566
4. 50. Plan's network characteristics-providers represented	3.632	19	0.542
6. 44. Plan provision of prior notification of on-site reviews	3.632	19	0.542
9. 14. Choice of hospitals available to members	3.611	18	0.511
9. 1. Availability of primary care physicians to members	3.588	17	0.476
12. 10. Overall quality ratings of plan	3.588	17	0.476
6. 17. Plan's communications processes	3.579	19	0.461
12. 8. Plan's reputation for quality of care	3.556	18	0.426
5. 31. Terms of plan payer agreements described to providers	3.556	18	0.426
11. 12. Plan's emergency care coverage	3.556	18	0.426
3. 5. Plan's provider contract terminations	3.556	18	0.426
6. 15. Plan's account service processes	3.556	18	0.426
9. 19. Member access to care	3.529	17	0.386
5. 3. Plan's effectiveness of member education on benefit design and limits	***3.526***	19	0.381
6. 43. Plan provision of appropriate medical record releases	3.526	19	0.381
3. 11. Laboratory "carve-out" delays	3.500	18	0.341
4. 4. Plan's enrollment trends	3.500	18	0.341
7. 14. Plan's degree of implementation of clinical guidelines for utilization mgmt.	3.500	18	0.341
5. 10. Plan's history of failure to pay bonuses to providers	3.500	18	0.341
6. 34. Ease of obtaining approval for rehabilitative care for members	3.474	19	0.301
4. 2. Plan's enrollment by payer-covered lives by payer	3.474	19	0.301
6. 37. Plan communication of employer lists to providers	3.474	19	0.301
10. 18. Physician satisfaction with care	3.444	18	0.256
2. 8. Availability of medical director-ability to contact medical director	3.444	18	0.256
6. 46. Accuracy of encounter data provided by plan	3.421	19	0.220
6. 35. Plan's services to providers	3.421	19	0.220
6. 14. Plan's customer service processes	3.421	19	0.220
9. 17. Choice of providers available to members	3.389	18	0.171

Managed Care Plan Performance Factor Survey Results by Std. Deviations	Avg	n	Std Devs
4.24. Plan's loss reserves	3.389	18	0.171
4.44. Plan's profit ratio-proportion of premium retained as profit	3.389	18	0.171
10.17. Physician satisfaction with plan	3.389	18	0.171
4.10. Plan's focus -- Long-term or short-term	3.368	19	0.140
3. 4. Plan's threats of provider termination	3.368	19	0.140
4.46. Plan's per-member-per-month expenses	3.368	19	0.140
6. 7. Plan's procedures for handling of out-of-network claims	3.368	19	0.140
12.14. Plan's reporting of quality measures	3.353	17	0.116
9. 4. Plan's use of primary care physician "gatekeepers"	3.333	18	0.086
11. 2. Plan's benefits to members	3.333	18	0.086
4.13. Plan's premium rate trends	3.333	18	0.086
6.33. Ease of obtaining approval for psychiatric care for members	3.316	19	0.059
4. 5. Plan's enrollment by county/MSA-covered lives by county/MSA	3.316	19	0.059
6.16. Plan's decision-making style	3.316	19	0.059
6.30. Plan's percent of aborted calls-hang ups from hold	3.316	19	0.059
4. 9. Plan's years in business	3.316	19	0.059
6.45. Timeliness of encounter data provided by plan	3.316	19	0.059
9. 9. Choice of primary care physicians available to members	3.294	17	0.026
12.13. Participating hospitals' accreditation status	3.294	17	0.026
9.18. Availability to members of information on participating providers	3.278	18	0.001
12. 2. Plan's affiliation with physician groups recognized for quality	3.278	18	0.001
6. 5. Plan members' ability to contact plan	3.278	18	0.001
10. 3. Member satisfaction with providers	3.235	17	-0.064
9.24. Member convenience of location of physician offices	3.235	17	-0.064
10. 4. Member satisfaction with choice of providers	3.235	17	-0.064
9.11. Choice of specialists available to members	3.235	17	-0.064
12.17. Plan's medical director qualifications	3.235	17	-0.064
12. 1. Participating physician board certification rates	3.235	17	-0.064
9.28. Member access to emergency care	3.235	17	-0.064
9.32. Provisions for out-of-area care for members	3.235	17	-0.064
4.14. Plan's financial leverage	3.222	18	-0.084
4.30. Plan's cash flow	3.222	18	-0.084
12. 7. Independent experts' ratings of plan	3.222	18	-0.084

Managed Care Plan Performance Factor Survey Results by Std. Deviations	Avg	n	Std Devs
11. 6. Plan's home care coverage	3.222	18	-0.084
4.45. Plan's cost-effectiveness of care	3.211	19	-0.102
2. 7. Plan's inpatient average length of stay	3.211	19	-0.102
12.16. Participating physician performance measurement efforts	3.176	17	-0.154
12.15. Plan's performance measurement efforts	3.176	17	-0.154
12. 9. Participating physicians' reputation for competence	3.167	18	-0.169
4.15. Plan's operating leverage	3.167	18	-0.169
4.18. Plan's reinsurance program	3.167	18	-0.169
9. 2. Plan's ratio of members per primary care physician	3.167	18	-0.169
4.33. Plan's net income	3.167	18	-0.169
7.19. Plan's reputation for coordination of care	3.158	19	-0.182
4.12. Plan's premium rate levels	3.158	19	-0.182
9.16. Member convenience of location of hospitals and ancillaries	3.118	17	-0.244
9.10. Member ease of getting appointment with primary care physician	3.118	17	-0.244
4.38. Plan's lines of business	3.111	18	-0.254
12. 4. Plan's quality improvements record	3.111	18	-0.254
4.17. Plan's spread of risk	3.111	18	-0.254
7.18. Plan's reputation for continuity of care	3.105	19	-0.263
10. 5. Member overall satisfaction	3.059	17	-0.334
10. 1. Member satisfaction with care	3.059	17	-0.334
9. 8. Number of physicians participating in plan	3.059	17	-0.334
4.32. Plan's cash and near cash balances	3.056	18	-0.339
10.13. Member intention to re-enroll	3.056	18	-0.339
4.16. Plan's asset leverage	3.056	18	-0.339
6. 4. Plan's paperwork requirements for members	3.056	18	-0.339
9.27. Plan's average times per year members visited emergency room	3.000	18	-0.423
9.13. Member access to specialists	3.000	17	-0.423
4. 3. Plan's rate of payer/member disenrollments	3.000	19	-0.423
2. 2. Plan's rate of high-occurrence/high cost DRGs	3.000	19	-0.423
10.16. Member out-of-pocket costs	3.000	17	-0.423
11.11. Plan's preventive care coverage	3.000	18	-0.423
7.17. Plan's reputation for thoroughness of care	2.947	19	-0.504
4.28. Plan's net worth	2.944	18	-0.508

Managed Care Plan Performance Factor Survey Results by Std. Deviations	Avg	n	Std Devs
11. 10. Plan's mental illness coverage	2.944	18	-0.508
7. 12. Plan's disease management programs	2.944	18	-0.508
4. 19. Plan's total assets	2.944	18	-0.508
12. 12. Professional organization disciplinary action rate against participating provid	2.941	17	-0.513
2. 1. Plan's inpatient utilization rates-admissions per thousand members	2.895	19	-0.584
4. 6. Plan's age/gender enrollment distribution	2.895	19	-0.584
4. 49. Plan's organization and structure	2.895	19	-0.584
11. 7. Plan's long-term care coverage	2.889	18	-0.593
11. 9. Plan's out-of-network coverage	2.889	18	-0.593
11. 4. Plan's use of formularies	2.889	18	-0.593
9. 5. Availability of pediatricians to members	2.882	17	-0.603
10. 19. Physician willingness to recommend plan	2.882	17	-0.603
10. 8. Member satisfaction with primary care physician	2.882	17	-0.603
9. 3. Percentage of participating practices closed to new patients	2.882	17	-0.603
10. 6. Member willingness to recommend plan	2.882	17	-0.603
9. 29. Member access to out-of-network emergency care	2.882	17	-0.603
10. 20. Physician stress/morale	2.875	16	-0.615
4. 39. Plan's market risk	2.833	18	-0.678
4. 37. Plan's industry sector	2.833	18	-0.678
6. 31. Plan's ratio of member services staff per 1,000 members	2.833	18	-0.678
11. 5. Flexibility of plan's formulary policies	2.833	18	-0.678
9. 25. Member ease of making physician appointments	2.824	17	-0.693
9. 22. Report rate of members having problems finding physician	2.824	17	-0.693
9. 23. Availability of member self-referrals for Ob/Gyn	2.824	17	-0.693
10. 24. Member satisfaction with coverage of plan	2.824	17	-0.693
9. 30. Member access to out-of-network physicians	2.824	17	-0.693
2. 6. Plan's ratio of hospital days per member	2.789	19	-0.745
7. 15. Plan's tracking of patient outcomes	2.778	18	-0.763
4. 20. Plan's quality of assets	2.778	18	-0.763
5. 8. Percent of plan's participating primary care physicians paid by capitation	2.778	18	-0.763
10. 29. Member ratings of respect given to patients	2.765	17	-0.783
10. 23. Member satisfaction with courtesy of physicians	2.765	17	-0.783
10. 22. Member complaint ratio	***2.765***	17	-0.783

Managed Care Plan Performance Factor Survey Results by Std. Deviations	Avg	n	Std Devs
4.31. Plan's debt service coverage	2.722	18	-0.848
4.29. Plan's risk-adjusted capital	2.722	18	-0.848
9.26. Plan's average times per year members visited doctor's office	2.722	18	-0.848
3. 1. Member "hassle" factor	2.722	18	-0.848
12.11. Malpractice judgements against participating providers	2.706	17	-0.873
10. 9. Member satisfaction with specialists	2.706	17	-0.873
10.10. Member satisfaction with office staff	2.706	17	-0.873
9.20. Member average waiting time for physicians	2.706	17	-0.873
10.12. Member satisfaction with customer service	2.706	17	-0.873
8. 8. Quality of plan's preventive care programs	2.684	19	-0.906
8. 4. Plan's rate of screening mammographies for members	2.667	18	-0.933
4.35. Plan's revenue composition	2.667	18	-0.933
7.28. Plan's breast cancer services available to members	2.667	18	-0.933
4. 8. Plan's physician turnover rate	2.667	18	-0.933
10.27. Member relationship with physician	2.647	17	-0.963
9.31. Member pharmacy access	2.647	17	-0.963
10.28. Member ratings of physician communications	2.647	17	-0.963
10. 7. Member trust in plan	2.647	17	-0.963
10.26. Member satisfaction with physician manner	2.647	17	-0.963
4.47. Plan's ownership status (for-profit or not-for-profit)	2.611	18	-1.018
4.21. Plan's diversification of assets	2.611	18	-1.018
7.24. Postsurgery complication rates at plan's participating hospitals	2.611	18	-1.018
11. 3. Plan's prescription drug benefits	2.611	18	-1.018
7.25. Hospital-acquired infection rates at plan's participating hospitals	2.611	18	-1.018
9.21. Member access to physicians by phone	2.588	17	-1.053
10.25. Member rating of overall health status	2.588	17	-1.053
7. 4. Plan's Cesarean section rate for deliveries	2.556	18	-1.103
4.27. Plan's capital structure	2.556	18	-1.103
7.22. Plan's rate of prenatal care for members	2.556	18	-1.103
7. 6. Plan's outpatient drug utilization rates	2.556	18	-1.103
9.12. Plan's ratio of members per specialty care physician	2.556	18	-1.103
8.12. Percent of plan members visiting PCP in past 3 years	2.526	19	-1.148
7. 1. Plan's rate of beta-blocker treatment after member's heart attack	2.500	18	-1.188

Managed Care Plan Performance Factor Survey Results by Std. Deviations	Avg	n	Std Devs
8. 7. Plan's rate of prostrate screening exams for members	2.500	18	-1.188
8. 6. Plan's rate of well-child visits for members	2.500	18	-1.188
7.26. Plan's rate of heart bypass surgery utilization	2.500	18	-1.188
7.27. Plan's rate of angioplasty procedures utilization	2.500	18	-1.188
8. 1. Plan's childhood immunization rates for members	2.500	18	-1.188
7.16. Plan's reputation for time physicians spend with patients	2.500	18	-1.188
8. 2. Plan's adolescent immunization rates for members	2.444	18	-1.273
7. 9. Plan's record in mental health/substance abuse care	2.444	18	-1.273
8. 9. Plan's cholesterol screening rates for members	2.444	18	-1.273
8. 5. Plan's rate of cervical cancer screening exams for members	2.444	18	-1.273
4.41. Plan's event risk	2.444	18	-1.273
4.34. Plan's investment income	2.444	18	-1.273
7.23. Plan's pediatric asthma admission rates	2.444	18	-1.273
10. 2. Member satisfaction with interpersonal care	2.438	16	-1.283
7. 5. Plan's rate of normal delivery after C-section delivery	2.389	18	-1.358
8.10. Plan's rate of members staying healthy	2.389	18	-1.358
8.11. Plan members' need for preventive services	2.389	18	-1.358
7. 2. Plan's rate of eye exams for diabetic patients	2.389	18	-1.358
7.20. Post-coronary death rates for plan's participating hospitals	2.389	18	-1.358
7.10. Plan's rate of foot exams for diabetic patients	2.389	18	-1.358
5. 9. Percent of plan's participating primary care physicians paid by salary	2.389	18	-1.358
10.11. Member satisfaction with pharmacy plan	2.353	17	-1.413
10.14. Member satisfaction with premium	2.353	17	-1.413
9. 7. Availability of major depressive disorder providers to members	2.353	17	-1.413
4.23. Plan's investments in affiliates	2.333	18	-1.442
7.11. Plan's rate of blood sugar tests for diabetic patients	2.333	18	-1.442
7.21. Plan's rate of low-birthweight infants born to members	2.333	18	-1.442
4.26. Plan's credit risk	2.333	18	-1.442
7.13. Plan's rate of glaucoma testing of members	2.333	18	-1.442
9.15. Plan's ration of members per hospital	2.294	17	-1.502
10.21. Availability of continuing medical education for physicians	2.294	17	-1.502
7. 7. Plan's conservatism in breast surgery	2.278	18	-1.527
4.22. Plan's principal investments	2.278	18	-1.527

Managed Care Plan Performance Factor Survey Results by Std. Deviations	Avg	n	Std Devs
7. 8. Plan's record of treatment for major depressive disorders	2.278	18	-1.527
4. 25. Plan's interest rate risk	2.278	18	-1.527
7. 3. Plan's antidepressant medication management	2.278	18	-1.527
8. 3. Plan's utilization rate for smoking cessation programs	2.278	18	-1.527
9. 6. Availability of geriatricians to members	2.235	17	-1.592
2. 5. Plan's rate of member prescription compliance	2.222	18	-1.612
6. 8. Plan's appropriateness of premium billing to members/employers	2.222	18	-1.612
2. 3. Plan's rate of diabetic patient's hospital days per thousand members	2.167	18	-1.697
8. 13. Plan's flu immunization rates for members	2.167	18	-1.697
10. 15. Member reason for selecting plan	2.118	17	-1.772
4. 7. Plan's average member family size	2.111	18	-1.782
11. 8. Plan's dental coverage	2.111	18	-1.782
Mean	3.277		
Standard Deviation	0.654		

13	What other factors are important to you in managed care contracting?		
14	Is your hospital classified as urban or rural by the Medicare program?		18
15	Licensed bed size of hospital:	9377	18
16	More than 15 percent of its gross revenue from managed care health plans?		18
17	Would you classify your overall experience with managed care health plans?	0.529	17

APPENDIX E

The Main Survey Instrument

ROBERT LATIMER BARBER

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October 27, 1999

[Participant Name]
[Participant Address]
[Participant Address]
[Participant Address]

Dear [Participant Name]

You have been selected in a random statistical sample of hospital managed care executives, financial officers and chief executives to participate in a research project intended to begin the process of developing a mechanism for rating health plans from the perspective of participating hospitals. The research is being conducted for my doctoral project in the executive program in health administration and leadership at the Medical University of South Carolina. In my professional career, I am the director of managed care for a major southeastern hospital network.

In my research I have found that the existing rating and evaluation systems (NCQA, JCAHO) and the ratings in the popular literature (Consumer Reports, Newsweek, U.S. News & World Report, etc.) may not address factors that are important to hospitals about their business relationship with a health plan. Consequently, there may be little visibility of the plans' desirability to hospitals as business partners.

The enclosed survey includes the items that an expert panel of hospital managed care officers and finance officers has identified as the most important to hospitals from more than 300 rating factors identified in existing ratings and evaluations. This survey is intended to identify which of these factors is most important to a national cross-section of hospitals.

Your participation is important to the integrity of the study. Your participation will be strictly confidential. No one but I will see your responses and even I will not know who responds, unless you take advantage of the offer that follows. As a reward for your participation, for all requests received before November 12, 1999, I will send a copy of a brief paper that I have researched and written on steps that you can take to assure prompt payment by health plans.

Completion of the survey should take less than 20 minutes. Won't you please complete the survey right now and return it to me in the enclosed stamped, addressed, return envelope? Your participation will make a difference.

I thank you in advance for your participation.

Sincerely,

Robert L. Barber
Doctoral Candidate

Managed Care Plan Performance Factors Survey

For each factor below, please indicate how important each factor would be in an ideal situation in influencing your hospital's decision to contract with or continue your participation as a provider in a managed care plan or other health benefit plan of the most common type of plan in your market.

Please mark your answer based on your initial reaction and sense of relative importance of each factor to the contracting decision.

1. Plan Performance Factors	Somewhat Important				Extremely Important
Factor	1	2	3	4	5
1. Plan's medical mgmt. intrusiveness—involvement in patient care decisions					
2. Plan's utilization review procedures					
3. Unilateral reductions of bills by plan					
4. Complexity of plan's requirements of providers					
5. Provider problems with plan's compensation					
6. Plan's excessive requests for patient information					
7. Degree of financial risk transfer from plan to providers					
8. Plan's hospital compensation method—disc., per diems, per case, capitation					
9. Amendments by mutual agreement only					
10. Contract terms—balanced or biased to plan					
11. Requirement for plan payment promptness in contract					
12. Plan's use of exclusive provider contracts					
13. Plan discount levels acceptable					
14. Contract overall equity and fairness					
15. Payer contracts required by PPOs to discourage silent PPOs					
16. Termination language—balanced and fair					
17. No "most-favored-nation" clause					
18. Plan's physician compensation method—fee-for-service, disc., capitation					
19. Plan's usage of patient financial incentives (steerage)					
20. Definition of "clean claim"—to start prompt payment clock					
21. Confidentiality of rates to discourage silent PPOs					
22. Fairness of plan's compensation to providers—relative to other plans					
23. Provider/plan responsibilities clearly defined in contract					
24. Use of member ID cards with plan logo required					
25. Plan's use of physician incentives—bonuses, capitation add-ons					
26. Limitations on retrospective review and denials					
27. Identification in contract of services to be provided					
28. Definition of medical necessity					
29. Confidentiality clause not really a "gag" clause					
30. Arbitration requirements fair					
31. Indicators of plan's financial stability					
32. Plan's promptness in provider payments					
33. Plan's rate of payment accuracy—percentage of payments right the first time					
34. Plan's promptness in correction of disputed payments					
35. Degree that necessary information is shown on plan member ID card					
36. Plan's promptness in responding to authorization requests					
37. Plan's requirements for authorization of treatment					
38. Convenience of plan's member eligibility verification process					
39. Plan's promptness in requesting further information needed for payment					
40. Plan's average days of claims backlog—degree of payment delays					
41. Convenience of plan's authorization procedures for providers					
42. Plan's procedures for authorization of treatment					
43. Ease of filing electronic claims with plan					
44. Plan's appeals process for medical necessity denials					
45. Accuracy of plan's eligibility reports					
46. Participating physician's staff knowledge of referral procedures					
47. Plan's promptness in responding to eligibility verification requests					

Please answer question 2 below to indicate how important the accreditation of a plan or its ratings is in your hospital's decision to contract with or continue your participation as a provider in a managed care plan or other health benefit plan of the most common type of plan in your market.

2. Plan Accreditation and Rating Factors

Factor	Not Important 1	2	3	4	Extremely Important 5
1. Plan accreditation by national organization					
2. Plan accreditation by National Committee for Quality Assurance (NCQA)					
3. Plan accreditation by Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)					
4. Plan's Health Employer Data Information Set (HEDIS) ratings					
5. Plan's Foundation for Accountability (FACCT) ratings					
6. Plan's rating by A. M. Best Ratings					
7. Plan's rating by Weiss Ratings, Inc.					

3. Is your hospital classified as urban or rural by the Medicare program? _____ Urban _____ Rural

4. Licensed bed size of hospital: _____ beds

5. Does your hospital receive more than 15 percent of its gross revenue from managed care health plans? _____Yes ____No

6. How would you classify your hospital's overall experience with managed care health plans? ____Favorable ___Unfavorable

Thank you for your participation.

If you would like a copy of the payment promptness paper, please complete the following:

Name: _____ Phone _____ Fax _____

Organization: _____

Address: _____E-mail _____

City: _____State _____ Zip _____