REFLECTIONS ON QUALITY:
NCQA at 25 Years
The National Committee for Quality Assurance (NCQA) was founded in 1990 to improve health care quality through measurement, transparency and accountability.

As the organization marks its 25th anniversary, six leaders from across the health care industry commented on the past and future of the quality movement, and on NCQA’s contributions to American health care.
Improving Population Health for 25 Years

Over 25 years, health plans have been transformed. Since 1990, the care that health insurers manage has shifted from a system with little oversight to one in which health plans are accountable for results. This is no small accomplishment, says Margaret E. O’Kane, President of the National Committee for Quality Assurance.

Looking back over two and half decades, O’Kane points out that quality improvement strategies were not usually applied to health plans until NCQA introduced accreditation and quality measurement standards.

“I’m surprised and heartened by the amount of progress we’ve made in these 25 years,” she says. “People are much more aware of the need to measure and manage health care quality. Not the average consumer or patient, perhaps. But certainly, policymakers and physicians are aware.”

Quality Focus Drives Improvement

Since 1990, the focus on care quality has intensified, in part because NCQA fostered many of the improvements found in health systems today, says O’Kane, identifying three significant NCQA accomplishments in particular.

First was the focus on improving patient care through the Healthcare Effectiveness Data and Information Set (HEDIS®). “One of our biggest achievements is having 171 million Americans in health plans that report HEDIS data.”
health plans that report HEDIS data,” she explains. HEDIS and other measurement systems promote improvements in care for patients with chronic conditions, such as asthma, diabetes and heart disease. “HEDIS is a trusted and widely used way of thinking about the health of populations and how well insurers deliver the optimal health members deserve.”

Raising Expectations and Spreading Good Ideas
“We saw the rate of complications for people with diabetes cut in half between 1990 and 2010. Before we and others put a focus on diabetes care, at least half of those patients didn’t see a doctor in a given year. Today, because of HEDIS, many diabetics’ blood sugar is managed to the recommended levels,” she says.

Second, NCQA transformed the idea about what consumers should expect from health plans. “Previously, health plans were passive purchasers of care. So, we said—and employers said—plans need to actively manage the health and quality of care patients receive, either by contracting with a quality systems organization or by taking on care management duties themselves. That was significant at the time, and it continues to be significant today.”

Third, NCQA developed a robust, well-used system to certify patient-centered medical homes (PCMH). “The patient-centered medical home takes many of the best ideas from health plans about how to manage the health of populations and turns those ideas into standards for primary care,” she says. “The PCMH model of care is one of the few ways the health system supports primary care, which is the bedrock of medicine. In patient-centered medical homes, we’re seeing the full flowering of primary care. That alone is a significant accomplishment.”

Movement Becomes a Mission
Another sign of extraordinary progress made in improving quality is the number of physicians and other providers who have become well-known leaders in the quality field. In the late 1980s, only a few doctors studied or wrote about quality improvement. “Today, there’s a whole field devoted to quality, and that alone shows how far we’ve come.”
As examples of physicians who have emerged as thought leaders, O’Kane cites Atul Gawande, MD, MPH, at Harvard; Jürgen Unützer, MD, MPH, at the University of Washington; and Sean Mackey, MD, PhD, at Stanford.

Gawande is a surgeon, author, researcher and Harvard professor of health policy and management, who is working improve patient outcomes. Unützer is a psychiatrist and researcher developing innovative ways to integrate mental health and primary care. Mackey is developing patient-reported outcome measures for patients in pain.

Before the focus on quality became commonplace, most Americans assumed their physicians, hospitals and other providers delivered the best care routinely. But U.S. corporations were aware of the value of implementing quality improvement processes and wanted to know if health plans were doing the same.

Incorrect Assumptions About Quality

“Many people assumed that our health care was good quality, and it’s hard to dispute that idea until you define quality specifically,” O’Kane says. “When the nation’s largest companies asked health plans about care quality, few could answer. Some didn’t even know how many of their members had diabetes, for instance.”

Until then, systems to evaluate quality were practically nonexistent. “We didn’t have a blueprint.”

Clearly, the nation needed an organization to advance a practical quality agenda. “The employers got us launched,” she says. From that point on, NCQA took one step after another to improve care—and had plenty of help along the way.

“We couldn’t have done any of this alone,” O’Kane declares. “What we were saying spoke to hundreds or even thousands of people who also care about quality. We are grateful to the many allies and champions who helped craft an effective quality agenda.”

Looking forward, O’Kane says, NCQA would like to support the development of accountable care organizations. “We have a terrific ACO accreditation program that could help standardize the way ACOs deliver care. The position of ACOs today is similar to the one health plans were in, in the late 1980s. If they are to be truly accountable, the health system needs a way to accredit them,” she concludes.
NCQA’s Leadership Was Needed in the 1990s and Is Needed Once Again

As odd as it may seem today, few people believed in 1990 that it was possible to measure the quality of care health plans delivered, says Debra L. Ness, President of the National Partnership for Women & Families. “Many people thought health care was as much an art as it was a science,” she explains. “How do you measure art, they asked. Just saying you could measure health care quality made NCQA a pioneer.”

In its early days, NCQA promoted even more radical thinking. “Two ideas—that we can measure health plan quality and that what gets measured gets improved—were foundational breakthroughs,” says Ness, who is a member of NCQA’s Board of Directors and chairs its Consumer Advisory Council. “Now, NCQA faces new challenges that involve measuring the value of care delivery models and ensuring that measurement reflects patients’ experience of care.”

The Demand for Standards

Looking back 25 years, it’s clear that poor quality and inadequate patient safety were so common that consumers and employers needed some way to ensure that health plans could meet specific minimum performance standards. “For these reasons, NCQA was absolutely needed,” Ness says.
Over the next decade, reports were published that underscored the need to address health care quality, including two from the Institute of Medicine. In 1999, the IOM published *To Err is Human: Building a Safer Health System*. Two years later, it published *Crossing the Quality Chasm: A New Health System for the 21st Century*.

“These reports made clear that a significant amount of harm was being done to patients inadvertently and that harm could be prevented,” Ness says. By accrediting managed care plans and by measuring the quality they delivered, NCQA began the process of improving care and making it safer for patients.

**Pursuing Higher-Value Care**

NCQA also began to identify effective ways to deliver care, and, Ness continues, “As we move to new models of payment and care delivery, we will need new methods of evaluating whether we are getting better care and better value for our money. NCQA has moved in that direction with such programs as recognition of patient-centered medical homes and the patient-centered specialty practice,” she says.

Reporting on the value of the care delivery system also may help drive out waste and inefficiency, problems that affect all patients. “Money spent on care that results in either harm or poor quality is lost to the health care system,” Ness says. “The fact that we spend so much on care that provides little value means we don’t have those dollars to spend on appropriate care. That waste has a particularly negative effect on patients and families struggling to survive economically.

“The more we waste, the more costs go up. Then, those increased costs get shifted back to consumers and families in the form of higher premiums and higher out-of-pocket costs,” she adds. “That’s why it’s important for NCQA to evaluate both the quality and the efficiency of care delivery. Measuring how well new models of care are delivering better care at lower costs is a different—but vitally important—kind of measurement.”
Evaluating Patients’ Experience of Care

In addition to evaluating quality and the efficiency of care delivery, NCQA is also working to evaluate patients’ outcomes and their experience of care, Ness says. “Clinical measures alone won’t tell us whether a patient is getting the care he or she needs or whether that care is delivered in a way that helps the patient achieve the best possible outcome.”

“Patient experience measures and patient-reported outcomes will be particularly important in assessing whether new payment and delivery models are improving health care for the most complex and costly patients, and this will become even more important as our population ages. Without considering patient-generated experience and outcome data, we could invest in new payment or delivery models that don’t meet the high bar we’ve set for better health outcomes, better care experience and smarter spending,” Ness says.

“Over the past 25 years, we’ve seen an evolution from the beginning embrace of measurement to assess quality, to measurement that drives quality improvement, greater transparency and payment aligned with value rather than volume. Measurement is continuously getting more focused and powerful. This shows us that measurement is both an essential foundation and a potent driver of the high-value patient-and family-centered health care system we seek,” she concludes.
Needing a Partner to Evaluate Quality, Employers Turned to NCQA

With the emergence of managed care in the late 1980s, the nation’s largest employers desperately needed a way to measure the quality of care that health plans delivered to employees and their families. When NCQA was founded in 1990, employers welcomed the news and saw NCQA as a partner in the fledgling field of health care quality improvement, says Brian Marcotte, President of the National Business Group on Health.

From this partnership, two developments stand out: the introduction of the Healthcare Effectiveness Data and Information Set (HEDIS) and the requirement that health plans contracting with large employers be accredited by NCQA.

HEDIS: A Most Important Initiative

“At that time, there were no quality standards, and a lot of problems with quality and safety,” says Marcotte, who was managing employee benefits for the Marriott Corporation. “That’s why HEDIS was one of the most important quality initiatives in health care. Before that, we had no way to measure quality.”

The Need for Best-Practice Measures

From what employers knew about quality improvement in their own companies, they recognized that health plans needed to identify and adopt best practices. For this reason, employers required health plans to adopt standardized process measures of quality, such as reporting on how many...
patients were getting beta-blockers after a heart attack. These quality measures were added as requirements in the first iterations of HEDIS.

“Twenty-five years ago, the percentage of patients prescribed beta-blockers after a heart attack was very low, even though doing so was considered a best practice. Now, we may not even need to track the use of beta-blockers after a heart attack because it’s a widely accepted practice,” Marcotte explains.

Employers also advocated for measures related to prenatal care, and the care for patients with chronic—and costly—conditions, such as asthma, diabetes and cardiovascular disease. “From my perspective, establishing quality measures with HEDIS was one of the major accomplishments in quality improvement,” he comments.

The second important development was the requirement that health plans become NCQA Accredited, which gave employers and employees confidence that plans were committed to providing high-quality care.

Managed care networks were just beginning to replace indemnity insurance when NCQA was founded, creating fears among workers about those networks’ quality. Marcotte spent part of every morning fielding complaints from employees who were upset about having limited choices for physicians and hospitals and who questioned the level of care from the new health plans.

**NCQA: Right Place, Right Time**

“When NCQA began to accredit plans, it was in the right place at the right time. NCQA was awarding what amounted to a seal of approval,” Marcotte says. “In those early days, only a few health plans were accredited, and so those plans stood out. Employers then promoted that information about their health plans, saying, ‘This is one way to be sure about the care you’re getting.’

“We still have a long way to go to ensure that health plans deliver the best possible care, but those first steps were significant,” he concludes.
Mark D. Smith, MD, MBA
Founding President, The California HealthCare Foundation

Needling a Partner to Evaluate Quality, Health System Turns to NCQA
Time and again over the past 25 years, NCQA has stepped in to fill a need in the health care system, says Dr. Mark D. Smith, founding President and former CEO of the California HealthCare Foundation. When NCQA was founded, consumers and employers needed an agency to ensure that managed health plans would deliver quality care. In response, NCQA began accrediting health plans and developed the Healthcare Effectiveness Data and Information Set (HEDIS).

Since then, NCQA has continued to measure quality as health plans have developed new forms of care delivery, Smith says. For several years, NCQA has been recognizing patient-centered medical homes, for example, and even accredits accountable care organizations.

A Middleman Emerges
At one time, there was little demand for evaluating health care quality. A patient went to the doctor and an insurance company paid the bill. Patients trusted physicians implicitly, believing they got high-quality care. “Before 1990, there was no middleman between physicians and patients,” Smith adds. “But as health plans became more aggressive, distrust ensued—whether rightly or wrongly.”

“The fact that the health system needed an independent agency to evaluate the quality of health plans was a brand-new idea. No other organization was doing this work in a scientific way.”
“The fact that the health system needed an independent agency to evaluate the quality of health plans was a brand-new idea. At the time, no other organization was doing this work in a scientific way, and plans were besieged by multiple, conflicting rubrics from benefits consultants, regulators and others. HEDIS was introduced in response to questions about managed care plans from the public, the medical profession and state and federal regulators.

“Therefore, NCQA had a significant role to play as an accrediting agency that not only would centralize the collection of plan metrics but also would standardize those metrics,” Smith explains. “By standardizing the metrics, NCQA allows employers and consumers to evaluate health plans and know that managed care plans attain basic levels of quality.”

Adapting to New Models of Care
What NCQA first did for health plans, it has continued to do for organizations that deliver care. When physicians and health plans began forming patient-centered medical homes, NCQA developed standards to recognize these entities—a way of organizing the delivery of primary care that emphasizes care coordination and communication to improve quality, reduce costs and improve patients’ experience of care.

“Seeing the need to define and assess medical homes, NCQA has adapted its processes as the health system has evolved. In this way, NCQA has become a leader in defining quality in these new models of care. At the same time, it can certify that physicians in medical homes are meeting specific standards,” Smith explains. “These developments show that NCQA is willing to do what’s necessary to ensure that quality care needs to be evaluated wherever it’s delivered.”

By evaluating and certifying the work that physicians do in different practice organizations, NCQA has adapted to changes in the marketplace. “The evolution of care means that our methods of measuring care have to evolve as well.”

New Settings, New Challenges
In the coming years, Smith envisions that care will be delivered in a wider variety of settings outside of hospitals and physicians’ offices. Patients are already getting care in drugstores, for example, over the phone and in the home. “So the challenge for NCQA will be to determine what any new form of care delivery will mean in terms of how to measure and report on quality,” he says.
Another shift is happening as hospitals, health systems, health plans and physician groups develop accountable care organizations. “By adapting its recognition models to medical homes and now to accountable care organizations, NCQA acknowledges that new organizations need the measurement, transparency and accountability that accreditation brings,” Smith says.

For NCQA, evaluating the quality of care in various settings is challenging because practices vary in the protocols they follow. “We still have a maddeningly uneven dissemination of evidence-based practice. We even have trouble getting health care providers to wash their hands,” he notes.

“Also, we’ve seen over the past 25 years a rapid dissemination of new drugs and devices, yet sometimes we don’t have sufficient evidence to support their use in clinical practice. Plus, we’ve seen physicians and hospitals develop strategies that can have big economic payoffs for some parties in the health care in the system, yet these strategies might not necessarily be best for patients.

“NCQA has been a valued partner since 1990 for consumers, employers, hospitals, physicians and other providers, but the job doesn’t get any easier. You could make the argument that evaluating health plan quality just gets more challenging every year,” he concludes.
Highlighting NCQA’s Lesser-Known Contributions
Over 25 years, NCQA has had a long list of well-known and important accomplishments. Yet over that same period, a number of significant achievements often have been overlooked, says Dr. J. Mario Molina, President and CEO of Molina Healthcare.

Among NCQA’s best-known accomplishments are reaching an agreement on ways to measure the quality of care health plans deliver, setting health plan accreditation standards and introducing the Healthcare Effectiveness Data and Information Set (HEDIS).

But NCQA also has played a significant role in helping state health departments measure the quality of care Medicaid plans deliver to the nation’s poorest consumers. In addition, NCQA has been able to unite diverse and sometimes opposing parties to agree on standards. Its work has served an important function that legislatures or regulators might otherwise do, but may not do as well.”

Improving Care in Medicaid Plans
By the late 1990s, state governments were beginning to contract with managed care plans for their Medicaid beneficiaries and, as enrollment grew, each state agency struggled to define quality, just as employers had done years earlier.

“The states had administrators, doctors and nurses crafting their own measures and their own quality improvement programs. They were creating a Tower of Babble.”
“In Medicaid agencies, there’s a lot of pressure to keep costs down and so they want to ensure that they’re receiving value for their health care dollars,” Molina says. “But in those early days, the states had administrators, doctors and nurses crafting their own measures and their own quality improvement programs. They were creating a Tower of Babel because each one was using different words, different programs and different standards.

“There was a huge need to standardize quality until NCQA provided a national accreditation standard for health plans that any state could apply. This allowed the states and the federal government to compare quality across the board,” he adds.

“In Medicaid plans, quality is often about life and death. And, these contracts involve lots of money. Any state contracting with multiple plans for hundreds of thousands of members needs to evaluate performance. Without NCQA, state Medicaid programs might have continued to struggle,” Molina explains.

Bringing Opposing Sides Together
Working with the various state Medicaid directors allowed NCQA to demonstrate another of its valuable accomplishments: the ability to bring disparate parties together to agree on standards.

“NCQA’s role as a convener—to bring people together to talk about the best way to get results—often goes unnoticed. Yet, this role is critically important in health care. Someone has to get different people with different experiences and different points of view to sit at one table and craft policies around quality that serve the public as a whole. This is no small task, and NCQA does it well,” he says.

Smoothing the Way for Standards
When a variety of parties agree on standards, implementing those standards becomes much easier than it would be otherwise. “Once NCQA was able to get agreement on how to measure performance and what data to use, then all the various sides were able to say, ‘Employers want it, health plans want it and the government wants it. So, we’ve got to report it.’”
Care standards for patients with asthma, diabetes and heart disease are examples of NCQA’s ability to reach consensus and to improve the care of these patients. “In general, it’s difficult to get doctors to change the way they practice. Therefore, you need agreed-upon guidelines that all can support, and that’s something NCQA does efficiently.”

**Precluding the Need for New Laws**
Even with agreement on national quality standards, critics often suggest that new laws or regulations are needed. Simply by developing national standards, NCQA’s work can preclude the need for new rules or legislation, and this too is a frequently overlooked ability.

“So often I hear people say that we need to pass a law or regulators want a new rule,’” Dr. Molina says. “In response, I explain that if you want to improve care in a particular area, you need the proper incentive. The best course of action is to pick the right HEDIS measure, because the industry will run toward that target. If we decide that every man of a certain age should have a prostate-specific antigen (PSA) test and make that a HEDIS measure, health plans will move toward that goal.”

The PSA test is a good example because at one time, it was considered a standard of care. “Since then, we learned that measuring PSAs creates a situation where a lot of men get unnecessary biopsies. Therefore, we backed away from that standard. If the states had passed laws requiring PSA tests, then those laws might have been difficult to repeal. That’s why it’s important to have meaningful and scientifically valid measures. Then if they are unneeded later, NCQA can revise its standards,” Molina explains.

Molina foresees a role for NCQA in improving safety for hospitalized patients and for those treated as outpatients. NCQA should also consider how to improve services delivered in long-term care settings, he suggests. “We need to be more sophisticated about how we measure hospital quality and we need to consider where we’ll be in the coming years. As more patients move into long-term care, we need to measure quality in those facilities.”
NCQA’s Quality Focus Helps Hospitals

Historically, hospitals and health systems have not had a strong focus on standards or a deep understanding of continuous improvement processes, says Dr. Gary S. Kaplan, Chairman and CEO of the Virginia Mason Health System in Seattle.

That lack of standards and processes led in part to the founding of NCQA in 1990, he says. “NCQA recognized that we needed standards, that we needed measurement metrics and oversight to ensure that we were delivering quality health care,” he says. “We had a lot to be proud of in health care, but NCQA saw that we could be a lot better.”

Physicians, Hospitals Aim Higher

By requiring quality measurement for health plans, NCQA introduced the idea that all providers needed to aim higher. “Getting hospitals and health systems to focus on quality improvement is a big accomplishment that led to a much deeper understanding of the opportunity to improve both quality and patient safety. As a result, the issues of quality and safety are on the radar screens of hospital administrators and governing boards,” Kaplan comments.

“The leadership that NCQA provided over the past 25 years and the standards it set led to a new focus on patient safety, including the campaign by hospitals and others to save 100,000 lives,” he
says. A project of the Institute for Healthcare Improvement, this effort later grew to become the 5 Million Lives Campaign.

NCQA has also been instrumental in fostering transparency about the quality of care that hospitals deliver and about improving patient safety, Kaplan adds. “NCQA’s work is significant because change takes time, and change in a change-averse industry takes a lot of time.”

As a result of NCQA’s focus on improving quality and safety, hospitals, health systems and all providers have adopted a vision of continuous quality improvement, and Virginia Mason is one of the nation’s best examples of this trend.

**Better Quality, Safer Care**

“We’ve shown through our Virginia Mason Production System that providing higher quality and safer care actually lowers costs,” Kaplan adds. “That may be counterintuitive to those who believe that the best care is more expensive. But actually, what happens when you take waste out of processes is you reduce costs and create safer, higher-quality care.”

Despite such progress, much more remains to be done. “I don’t want to be deluded into thinking that everything’s moving in the right direction now and so we no longer need to be vigilant. Instead, we need to push even harder, because while there are places in this country that are making breakthroughs, there are others that only pay lip service to quality improvement. We need to move faster. Our patients are counting on us. By continuing to refine the metrics we use for improvement and by continuing to hold the health system accountable for quality and safety, we can accelerate change,” he concludes.
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