

# Strengthening the Consumer Voice in Managed Care: II. Moving NCQA Standards From Rights to Empowerment

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Like apple pie and motherhood, the premise that consumers should have a strong voice in shaping managed care policies and practices will not encounter much opposition. Unfortunately, with few exceptions (1), the consumer's voice is little heard and rarely effective in current managed behavioral health practice.

An earlier column (2) and a forthcoming book (3) argue that a core challenge for all health care systems—whether market-based, as in the United States, or single-payer, as in Canada—is setting limits that are clinically informed, ethically justifiable, and politically acceptable. This challenge can be met only if limit-setting programs such as managed behavioral health organizations are held accountable for the reasonableness of their practices (4). Accountability for reasonableness requires three elements: transparency of organizational policies and decisions, deliberation that recognizes the needs of both the

individuals and the population served, and opportunity for appeals and revision of limit-setting policies.

Without the robust voice of the consumer, these three conditions are unachievable. Like truly informed consent, transparency requires an ongoing dialogue with consumers, not simply bureaucratic “disclosure.” When policy deliberation is left to beleaguered managers, fewer options are generated than when consumers participate. And without real give and take between managers and consumers, complaints and appeals will not produce learning and appropriate policy revision within organizations.

The National Committee for Quality Assurance (NCQA) sets standards for managed behavioral health organizations and accredits organizations according to those standards. NCQA standards reflect a vision of good practice. Although accreditation is voluntary, it is, like board certification in psychiatry, highly desirable and sometimes required. Thus the accreditation process is a form of enforcement.

In this column we examine the vision of consumer voice embedded in NCQA standards. Current standards (5) provide a good beginning for achieving legitimacy through accountability for reasonableness. We present a strategy for making the standards even better.

## NCQA standards for consumer participation

NCQA standards reflect the three main approaches American psychiatry has taken to the role of the con-

sumer since World War II—rights, satisfaction, and empowerment (6).

## Rights

The standards' most explicit approach to strengthening the consumer's role is through emphasis on rights. Enrollees' rights and responsibilities constitute one of the six domains of standards; the other five domains are quality improvement, utilization management, credentialing, prevention, and treatment records. The enrollees' rights and responsibilities domain accounts for nine of the 100 points in the scoring process.

The objective of this domain is the promotion of the organizational equivalent of a therapeutic alliance between enrollees and the managed behavioral health organization: “To promote effective behavioral health care, a quality managed behavioral health organization is committed to maintaining a mutually respectful relationship with its enrollees. When the managed behavioral health organization makes clear its expectations regarding the rights and responsibilities of enrollees, it creates a structure for cooperation among enrollees, practitioners, and the managed behavioral health organization” (5).

The rights and responsibilities domain stipulates what enrollees can expect in terms of written statements of policies and procedures for important areas of the organization's activity. Thus the fourth rights and responsibilities standard requires the managed behavioral health organization to provide “each subscriber with the infor-

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mation needed to understand benefit coverage, how to obtain behavioral health care services, and how to obtain necessary care" (5). Like the other rights put forward in this domain, standard 4 is clearly a necessary building block for effective consumer voice.

The opportunities for improvement in the rights and responsibilities domain come from raising the bar, by specifying in more detail what members have a right to expect from their managed behavioral health organizations.

### ***Satisfaction***

The NCQA standards are comparably explicit about the role of consumer satisfaction surveys. The sixth quality improvement standard, which accounts for 5.3 points of the 100-point total, requires the managed behavioral health organization to assess and ensure enrollee satisfaction through a survey conducted at least annually. The standard spells out expectations for what should be surveyed, the survey methods, analysis of the findings, corrective action, and monitoring of results. NCQA encourages managed behavioral health organizations to begin using the Experience of Care and Health Outcomes (ECHO) survey (7), which it is likely to require as of 2003. This survey contains questions that clinicians are likely to regard as important and on target for assessing the performance of managed behavioral health organizations.

The requirements for surveys are well articulated and focus on clinically important areas. The opportunities for improvement lie in better specification of the consumer's role in interpreting survey results.

### ***Empowerment***

Although "empowerment" is a less precise concept than "rights" or "satisfaction," it is especially important to consumers, because it connotes effective activism and a capacity to influence one's destiny (8). Some of the NCQA standards require or recommend consumer involvement in the organization's management process. Empowerment is most explicitly required in the standard related to quality improvement operations (standard 2.3), which specifies that the organi-

zation must have "mechanisms to ensure that practitioners and enrollees help to plan, design, implement, or review the quality improvement program" (5).

In the same spirit, the standard that requires clinical practice guidelines requires "input from practitioners and enrollees" (quality improvement standard 8.2), and the standard that calls for preventive programs specifies that the managed behavioral health organization "enlists the participation of practitioners, providers, enrollees, and community agencies" (prevention standard 1). And, in a casual but important comment, NCQA gives as an example of "organizational commitment to improving safe clinical practice" informing enrollees about "research findings that facilitate decision-making" (quality improvement standard 1.1), a practice that would enhance the consumer's capacity to participate effectively in a wide range of policy-making processes.

The ways in which NCQA standards promote empowerment are less fully developed than the requirements for rights and responsibilities or satisfaction surveys. We believe that empowerment presents the key opportunity for near-term improvements in the impact of the standards on consumer voice.

### **Strengthening NCQA's support for consumer voice**

As measured by the three components of accountability for reasonableness—transparency, deliberation, and appeals and revision—NCQA's behavioral health standards provide strong support for transparency and appeals and revision and represent a good start for deliberation. The main changes for strengthening the consumer's voice involve specifying who should participate in deliberation about policy and how that deliberation should be conducted.

With regard to who participates in policy deliberation, the 2001 standards already require consumer participation in the domains of quality improvement and prevention. The next set of standards should extend that requirement to the utilization management domain, which is where the rubber meets the road in managing resource

use. Utilization management standard 2.2 currently requires the managed behavioral health organization to involve "appropriate, actively practicing practitioners in its development or adoption of [utilization management] criteria." In the next set of standards, a phrase such as "and enrollees" should be added after "practitioners."

In the quality improvement domain, a one-word change could substantially strengthen support for accountability for reasonableness. We have observed programs in which consumers receive reports of completed quality improvement projects under circumstances that allow for passive listening but no meaningful participation. This perfunctory form of show-and-tell would meet the current requirement "that practitioners and enrollees help to plan, design, implement, or review the quality improvement program" (quality improvement standard 2.3). Changing "or" to "and" would be consistent with best practices for managed behavioral health organizations and would raise the expectation bar in a meaningful way.

With regard to how policy deliberation should occur, the 2001 standards convey a clear understanding that managed behavioral health programs are responsible for meeting the needs of both the individual and the population in the context of inevitably limited resources (prevention standard 1). The essence of managed care is setting priorities and considering cost-effectiveness (utilization management standard 3) within the resource pool. Thus decisions about policies should be based on considerations that are relevant to meeting individual and population needs within resource constraints. NCQA standards can strengthen and enforce this expectation.

The strongest expectations about the rationale for policies are in the standard for denial notices, which requires that a managed behavioral health organization "clearly documents and communicates the reason for each denial" (utilization management standard 6). Commendably, the NCQA manual gives five examples of acceptable reasons and three examples of unacceptable ones.

One example of an acceptable reason listed in the manual is, "The en-

rollee no longer requires care in a hospital because he/she is not a danger to self or others and can be appropriately managed in an intensive outpatient program" (utilization management standard 6.2). Although this reason would be vastly better than "the treatment is determined to be not medically necessary," which is listed as an example of an unacceptable reason, it is not good enough. Suppose that hospital care is not clinically contraindicated, and the patient, the family, and the practitioner all prefer hospitalization to intensive outpatient treatment. Perhaps a 22-year-old patient's continued paranoid utterings are disturbing the younger children at home, or the patient, the family, and the practitioner believe the patient's medication could be fine-tuned better in the hospital. In these circumstances they would not and should not be satisfied by NCQA's reason.

What would satisfy these individuals, other than coverage of the continued hospital care they desire? In a prepaid group practice—or in a Canadian province (9)—a reason such as the following might lead them to see the denial as fair, although disappointing: "In order to offer the fullest possible range of services to the insured population within our budget, our clinical policy calls for the use of alternatives to hospitalization whenever possible." In a self-insured or commercial account, a reason such as the following might have the same result: "In order to offer behavioral health coverage to our employees at an affordable price, our clinical policy calls for the use of alternatives to hospitalization whenever possible."

Of course, the persuasiveness of these reasons would depend on their being true. By requiring that explanations of denials include reasons that would be considered fair by the recipient, NCQA could advance the honesty of the climate in which care is managed and put pressure on managed behavioral health organizations to be more accountable for the reasonableness of their policies and practices.

## Conclusions

NCQA intends to maintain its current set of standards until June 30, 2003, which gives consumer advocates ample time to explore ways in which the

next version could further strengthen the consumer's voice in managed behavioral health care. The suggestions we have made would promote greater transparency about the provision of health care in the context of finite resources and more robust consumer participation in the policy-making process.

Although our suggestions involve small changes in the wording of standards, if taken seriously they would produce significant changes in the way managed behavioral health organizations conduct themselves. Applying accountability for reasonableness would require a substantial societal learning curve. Promoting such learning is consistent with NCQA's mission of supporting progressive quality improvement and public education. ♦

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## ECONOMIC GRAND ROUNDS

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lization (1). We are all now operating in a more cost-efficient framework, with even specialty units keeping their mean length of stay well below the 30-day ceiling theoretically mandated by Medicaid. Nevertheless, patients' needs continue to be a reality, and as managed care attempts to embrace the entire spectrum of severe psychiatric disorders, not just those typically seen in the commercially covered population, we find that there are clinical limits to reducing length of stay, whether care is managed or unmanaged.

Given these realities, the question arises as to whether we still need the added cost and burden of daily utilization review and case management. This example suggests that physician practice may have been sufficiently influenced by the changes of the past decade and that we can now move on to a more collaborative, patient-focused relationship. The dollars diverted from expensive managed care overheads could be redirected toward more clinically urgent needs. These needs might include expanding coverage for the uninsured, improving the quality of services in rehabilitation and residential settings—which is so critical to preventing relapse and fostering eventual independence, both of which could also reduce costs—or directing additional resources toward that intractable but very real group of patients who remain treatment refractory and who consistently exceed the average length of stay, even for their particular diagnoses. There is still much work to be done. ♦

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