An Employer's Guide to Cancer & Treatment & Prevention

Tool 6: Evaluation and Plan Reporting

Background

The *Plan Design & Assessment* tool of *An Employer's Guide to Cancer Treatment & Prevention* (the *Guide*) describes benefit recommendations in detail, while the *Vendor and Program Management* tools provide a resource to generate RFP questions, evaluate responses and score and rank vendors.

> In *Making Strategy Work*, Timothy Galpin identifies "measurable goals and objectives as one of the key success factors making strategy work."[1]

The *Summary Plan Description Guidance* tool provides assistance in developing language for the SPD. The *Vendor Contracting and Administration* tool offers guidance for vendor contracting, including the information and data that employers should consider requiring from vendors. These resources are intended to be concrete and directly applicable to the work of benefit managers. In contrast, this tool provides a model that employers can use to both assess the performance of vendors and evaluate the overall effectiveness of the employee benefits.

This tool provides metrics for the *Guide's* recommendations for: (1) health plan benefits, (2) health and productivity programs and services and (3) health improvement programs. Health plan metrics include general medical (including behavioral health) and pharmacy benefits. Health and productivity program metrics are provided for short-term disability (STD), family medical leave (FML) and employee assistance programs (EAP). Although the *Guide* does not include benefit recommendations for long-term disability (LTD), metrics for this program have been included because it is important for employers to have basic information about the number of employees who have been placed on LTD because of cancer. Health improvement metrics that address program performance also are included.

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Because this tool includes all benefits, programs and services, it is considered an integrated evaluation. It encompasses a carefully selected set of measures based on the goal of providing evidence-driven cancer benefits, programs and services for employees and their dependents. The tool also provides specific evaluation criteria for recommendations and metrics included in the toolkit. The overarching goal of this evaluation model is to help employers measure how effective they have been in developing, implementing and providing evidence-driven benefits, programs and services to their employees and dependents. From this evaluation,

benefit managers and program directors can develop specific, continuous, quality improvement objectives.

The model includes four key domains and what should be measured in each one to continually assess the value of the program. The four measurement domains are described in the next section.

Development of the Evaluation Model

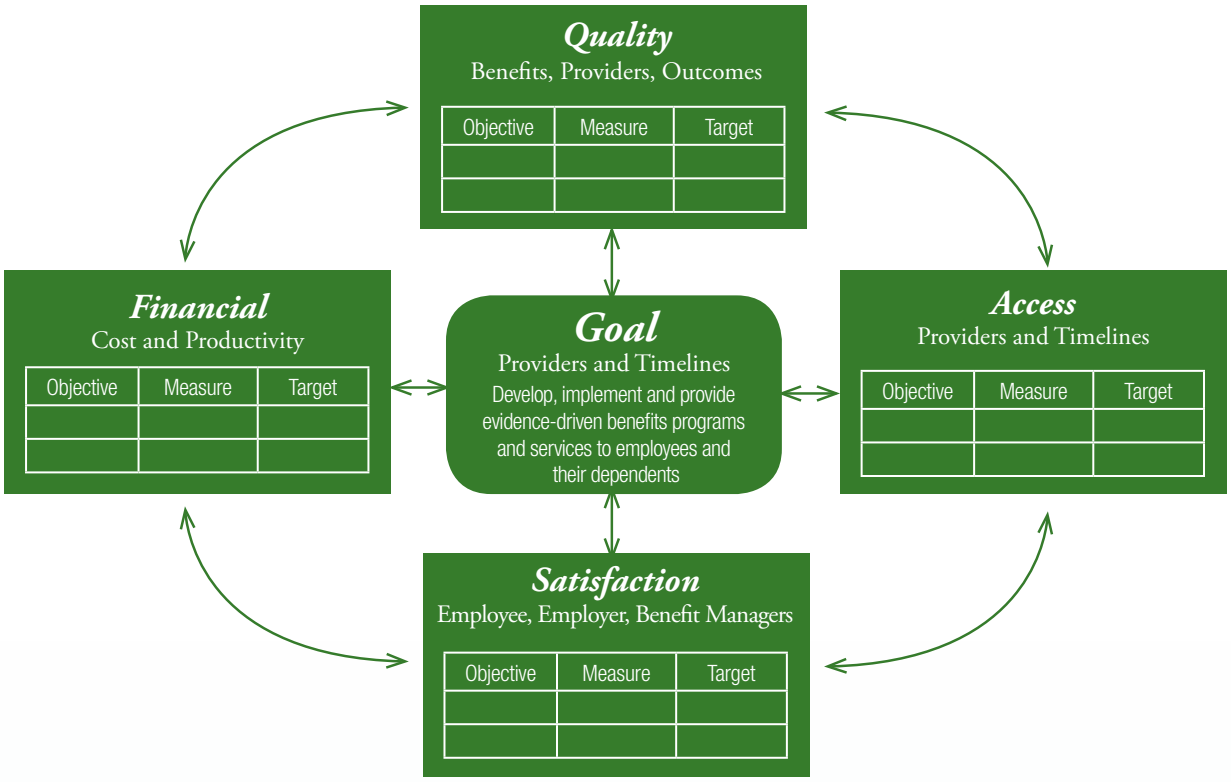
1. ***Quality:*** Measures quality of care and quality of life.
2. ***Access:*** Measures availability and convenient access to quality providers as well as timeliness of care delivery.
3. ***Financial:*** Measures net benefit costs to payers and employees and the impact on employee productivity.
4. ***Satisfaction:*** Measures level of knowledge of employee and dependent needs and how effectively and efficiently they are served. This includes indications of employees' knowledge of and perspectives on benefits, care and services. This domain also includes the benefit staff's satisfaction with their involvement and understanding of services, ability to serve employees and their dependents, and ease of both implementation and management of delivery of benefits and programs. Since satisfaction is difficult to measure, it is recommended that a criterion or norm-referenced scale be developed, which enables evaluation to be completed through the use of quantitative scales. For example, evaluation could be based on a scale of 1 to 10, where 1 represents complete dissatisfaction and 10 represents the highest level of satisfaction, with scores in between representing a continuum of satisfaction. These scales are known as Likert scales, and they can be developed with a narrow-to-large range of options along a continuum.

These domains and the measures associated with each one do not exist in isolation from each other. They are interconnected, with each providing a more complete understanding of the effectiveness of the overall strategy associated with the cancer benefits and services.

Figure 1 presents a visual concept of the relationship between the overarching goal of the benefits program and the four measurement domains.[2] It also illustrates the relationship and interaction among the domains. To achieve the goal of providing cost-effective and evidence-driven cancer benefits and services, a balance among the domain measurements is necessary. For example, while providing high-quality cancer benefits is the objective, achievement of this objective must be in balance with costs.

As shown in Figure 1, for each measurement domain, objectives, measures and targets need to be established in a chart called the evaluation matrix. *Vendor Contracting and Administration* (found at http://www.businessgrouphealth.org/pub/f31294d8-2354-d714-51f5-6e24cc93c733) provides objectives and metrics that can be applied to this process. Specific information about how to complete the evaluation matrix will be provided later in this document.

Figure 1: An Illustration of the Relationship Among Measurement Domains



How to Use the Metrics

Scoring of vendors' performance may be based on both objective and subjective criteria. The objective criteria for evaluation and reporting utilize metrics for: (1) the Medical Plan, (2) the Pharmacy Plan, (3) Centers of Excellence (COE), (4) Care Management, (5) Short-term Disability (STD), (6) Long-term Disability (LTD), (7) Family Medical Leave (FML), (8) Employee Assistance Programs (EAPs) and (9) Health Improvement Programs (HIPs). For some metrics, such as many associated with costs, baselines need to be established in order to develop year-over-year comparisons. If they are not available from your company, it may be possible, in some instances, to find industry-wide metrics. In any case, comparison data are important; their absence may complicate vendor evaluation in some areas of plan performance in the first year following benefit implementation.

Subjective criteria are often as valuable as objective measures. Ease of administration; rapport with vendor staff; willingness of the vendor to adapt and address problems and implement corrective action; willingness to develop a long-term, meaningful relationship; and employee feedback are important criteria that most benefit managers understand and include in their evaluations.

Specific Metrics for Plan Evaluation

Medical Plan Evaluation

Metric	Definition
Cancer–Specific Metrics	1. Provide overall metrics related to cancer at the end of each year, with a three-month run-out period. ICD-9 neoplasm diagnosis coding includes malignant neoplasms (cancer) (diagnosis codes 140.0-209.6), plus carcinoma in situ (230.0-234.9). Neoplasm codes include benign neoplasms (not cancer) (diagnosis codes 210.0-229.9), as well as neoplasms of uncertain behavior (235.0-238.9) and neoplasms of unspecified nature (239.0-239.9). Only malignant neoplasm categories (140.0-209.69 and 230.0-234.9) should be included in cancer reporting. Metrics should include, but not necessarily be limited to, the following: a. Total net paid for cancer (codes listed above); b. Average paid per claimant with any cancer diagnosis, excluding non-melanoma skin cancer (173.0-173.9), which are relatively frequent but inexpensive and can skew the data; c. Net paid per member per month (PMPM); d. Highest number of claimants, by type of cancer; e. Highest cost cancers across all beneficiaries, by type of cancer (total net paid and net paid PMPM); f. Highest cost cancers, average net paid by claimant; g. Number of claimants with cancer with relevant breakdowns, such as by state, gender, age (under 18, 18-50, >50); status (employee, dependent, retiree); and average cost per claimant with cancer (by applicable breakdown); h. Number of inpatient admissions with a diagnosis of cancer and average length of stay; i. Number of hospice admissions (if known) and average length of stay; and j. Total drug costs of cancer patients. 2. Provide metrics as described in Tool 5 at the end of each year, with a three-month run-out period. Tool 5 contains specific metrics for many of the benefit recommendations.
Utilization Review/Pre-certification	1. Report actual average turnaround time to provide coverage determination or prior approval when required. Turnaround time should be no greater than 72 hours for routine requests and no greater than 24 hours for urgent requests. (Refer to Tool 5, Benefit Recommendations 1.1, 1.5, 1.6, 1.9 and any other circumstances where prior approval/prior authorization is required by the plan.)
Evidence-driven Treatment	1. Describe data collection practices to measure the extent to which the cancer treatment of employees and their dependents is concordant with NCCN Guidelines®.

Metric	Definition
Pharmacy Out-of-Pocket Costs	Describe the medical plan's practices to coordinate with the pharmacy plan to ensure that: a. One out-of-pocket maximum is implemented across the medical and pharmacy benefit plans; and b. Parity of patient cost sharing is implemented between the medical and pharmacy benefit plans.
Health Plan Changes	Give prior notice of material changes in policies, practices and programs related to cancer, as described in Tool 5.

Pharmacy Plan Evaluation

Metric	Definition
Plan or Practice Change	1. Give prior notice of material changes in policies, practices and programs related to cancer, as described in Tool 5.
Cancer Pharmacy Utilization	Provide overall metrics related to cancer at the end of each year, with a three-month run-out period: a. Number of individuals obtaining cancer drugs and biologics through the pharmacy plan; and b. Total cost of cancer drugs and biologics (billed, paid and net paid) in the pharmacy plan.
Evidence-based Pharmacy Adherence	1. Describe data collection practices to measure the extent to which the cancer treatment of employees and their dependents is concordant with NCCN Guidelines®.
Copayment and Out-of-Pocket Expenses	2. Describe pharmacy plan's practices to coordinate with the medical plan to ensure that: a. One out-of-pocket maximum is implemented across the medical and pharmacy benefit plans; and b. Parity of patient cost sharing is implemented between the medical and pharmacy benefit plans.
Specialty Pharmacy Counseling	Provide aggregate data on employees and dependents served through the specialty pharmacy counseling program, if applicable.
Cancer Pharmacy Costs	Provide data on total specialty pharmacy costs for cancer medications.
Average Pharmacy Costs per Cancer Case	$\frac{\text{Total Pharmacy Costs for All Cancer Diagnoses}}{\text{Total Number of Cancer Cases}}$

Centers of Excellence (COE) Program
(as part of medical plan or from separate vendors)

Metric	Definition
Plan Changes	1. Provide prior notice of material changes in policies, practices and programs related to cancer and/or transplant COE programs, as described in Tool 5, Benefit Recommendations 1.2, 1.3 and 1.4.
COE Metrics	1. Provide overall metrics related to the cancer and/or transplant COE programs and, if applicable, the travel and lodging program, at the end of each year, with a three-month run-out period, as described in Tool 5, Benefit Recommendations 1.2, 1.3 and 1.4.

Cancer Care Management Program
(as part of medical plan or from separate vendors)

Metric	Definition
Plan Changes	1. Provide prior notice of material changes in policies, practices and programs related to cancer, as described in Tool 5, Benefit Recommendations 3.1 and/or 3.2, as applicable.
Care Management Metrics	1. Provide overall metrics related to care management services at the end of each year, with a three-month run-out period, as described in Tool 5, Benefit Recommendations 1.3 and 1.7, and Clinical Support & Condition Management Recommendations 3.1 and/or 3.2, as applicable.

Short-Term Disability (STD)
To arrive at the metric, divide the numerator by the denominator in the fractions shown below.

Metric	Definition	Multiplier (where appropriate)
Annual STD Claim Incidence per 100 Employees	Total Number of New STD Claims / Average Number of Employees Covered under STD Plan	x100
Annual STD Cancer Claim Incidence per 100 Employees	Total Number of New STD Cancer Claims / Average Number of Employees Covered by STD Plan	x100
Annual STD Cancer Claim Incidence Percentage per 100 Employees	Total Number of New STD Cancer Claims / Total Number of Active STD Claims	x100
Average STD Claim Duration	Lost Calendar Days Associated with Closed STD Claims / Total Number of Closed STD Claims	
Cost per Active Claim	Total Benefits Paid / Total Number of Active STD Claims	
Cost per Closed Claim	Total Benefits Paid for Closed STD Claims / Total Number of Closed STD Claims	
Annual Average STD Cancer Claim Duration	Total Number of STD days with Cancer Diagnosis / Total Number of STD Claims with Cancer Diagnosis	
Cost per Active Cancer Claim	Total Cost per Active Cancer Claim / Total Number of Active STD Cases with Cancer Diagnosis	
Average Cost per Closed Cancer Claim	Total Benefits Paid for Closed STD Claims with Cancer Diagnosis / Total Number of Closed STD Claims With Cancer Diagnosis	
Average Cost per Employee	Total Benefits Paid / Average Number of Employees Covered under STD Plan	
Lost Workdays per 100 Employees	Total Number of Lost Workdays / Average Number of Employees Covered under STD Plan	x100

Metric	Definition	Multiplier (where appropriate)
Lost Workdays per 100 Employees with Cancer Diagnosis	Total Number of Lost Workdays for Cancer Diagnosis ——————————— Average Number of Employees Covered under STD Plan with Cancer Diagnosis	x100
Return-to-Work (RTW) Claim Percentage	Total Number of Claims on RTW Transitional Duty ——————————— Total Number of Active STD Claims	
RTW Transitional Workdays Percentage	Total Number of Workdays with Employees on RTW Transitional Duty ——————————— Total Number of Lost Workdays	
RTW Claim Percentage for Cancer Diagnosis	Total Number of Claims on RTW Transitional Duty with Cancer Diagnosis ——————————— Total Number of Active STD Claims	
RTW Transitional Workdays Percentage for Cancer Diagnosis	Total Number of Workdays with Employees on RTW Transitional Duty with Cancer Diagnosis ——————————— Total Number of Lost Workdays for Cancer Diagnosis	
Work Accommodation	Total Number of Employees with Cancer for whom RTW Accommodations were made	
Referrals to EAP	Total Number of Cases Referred to EAP	
Referral with Cancer Diagnosis to EAP	Total Number of Cases Referred to EAP with Cancer Diagnosis	
Employee Satisfaction with STD	Average Employee Likert Score from Satisfaction Survey	
Supervisor Satisfaction with STD	Average Supervisor Likert Score from Satisfaction Survey	

Long-Term Disability (LTD)

To arrive at the metric, divide the numerator by the denominator in the fractions shown below.

Metric	Definition	Multiplier (where appropriate)
Annual LTD Claim Incidence per 1,000 Employees	Total Number of New LTD Claims ——————————— Average Number of Employees Covered under LTD Plan	x1,000
Annual LTD Cancer Claim Incidence per 1,000 Employees	Total Number of New LTD Claims with Cancer Diagnosis ——————————— Average Number of Employees Covered under LTD Plan	x1,000
Cost per Claim	Total LTD Benefits Paid ——————————— Total Number of Open LTD Claims	
Cost per Cancer Claim	Total LTD Benefits Paid for Cancer Diagnosis ——————————— Total Number of Open LTD Claims with Cancer Diagnosis	

Family Medical Leave (FML)

To arrive at the metric, divide the numerator by the denominator in the fractions shown below.

Metric	Definition	Multiplier (where appropriate)
Non-concurrent FML Claims per 100 Covered Employees	Total Number of Non-concurrent FML Claims / Average Number of Employees Eligible for FML	x100
Non-concurrent FML Claims per 100 Covered Employees with Cancer Diagnosis	Total Number of Non-concurrent FML Claims with Cancer Diagnosis / Average Number of Employees Eligible for FML	x100
Non-concurrent FML Lost Workdays per 100 Covered Employees	Total Number of Non-concurrent FML Lost Workdays / Average Number of Employees Eligible for FML	x100
Non-concurrent FML Lost Workdays per 100 Covered Employees with Cancer Diagnosis	Total Number of Non-concurrent FML Lost Workdays with Cancer Diagnosis / Average Number of Employees Eligible for FML	x100
Total FML Claims per 100 Covered Employees	Total Number of FML Claims / Average Number of Employees Eligible for FML	x100
Total FML Lost Workdays per 100 Covered Employees	Total Number of FML Lost Workdays / Average Number of Employees Eligible for FML	x100
Depression Screening	Total Number of FML Applicants that Completed Depression Screening	
Percent of FML Applicants that Screened Positive for Depression	Total Number of Applicants that Screened Positive for Depression / Total Number of FML Applicants	x100
EAP Referral	Total Number of Applicants Referred to EAP	
Employee Satisfaction with FML	Average Lickert Score from Satisfaction Survey	
Supervisor Satisfaction	Average Likert Score from Satisfaction Survey	

Employee Assistance Programs (EAPs)

To arrive at the metric, divide the numerator by the denominator in the fractions shown below.

Metric	Definition	Multiplier (where appropriate)
EAP Program Costs	EAP Program Costs / Average Number of Employees Covered for EAP	
Existing EAP Participation per 100 Employees	Total Number of Active EAP Cases / Average Number of Employees Covered for EAP	x100
Number of Active EAP Cancer Cases per 100 Employees	Total Number of Active Employee Cases with Cancer Diagnosis / Average Number of Employees Covered for EAP	x100

Metric	Definition	Multiplier (where appropriate)
Cancer Diagnosis	Total Number of Active Cases of Employees and/or their Dependents with Cancer Diagnosis	
New EAP Participation per 100 Employees	Total Number of New EAP Cases / Average Number of Employees Covered for EAP	x100
New EAP Participation with Cancer Diagnosis per 100 Employees	Total Number of New Cases with Cancer Diagnosis / Average Number of Employees Covered for EAP	x100
Percent of EAP Cases with Cancer Diagnosis	Total Number of EAP Cancer Cases / Total Number of EAP Cases	
Supervisor Consultation	Total Number of Supervisor Consultations for Employees with Cancer Diagnosis	
Supervisor Referral with Cancer Diagnosis	Total Number of Supervisor Referrals for Employees with Cancer Diagnosis	
FML Referral	Total Number of Employees Referred from FML	
STD Referral	Total Number of Employees Referred by STD Case Managers	
STD Referral for Employees with Cancer	Total Number of Employees with Cancer Referred by STD Case Managers	
Employee and/or Dependent Satisfaction	Average Employee or Dependent Likert Score from Satisfaction Survey	
Supervisor Satisfaction	Average Supervisor Likert Score from Satisfaction Survey	

Health Improvement Programs (HIPs)

To arrive at the metric, divide the numerator by the denominator in the fractions shown below.

Metric	Definition	Multiplier (where appropriate)
Health Improvement Program (HIP) Costs	HIP Costs / Average Number of Eligible Employees and Dependents	
Program Participation per 100 Eligible Employees and Dependents	Number of Program Participants / Number of Eligible Employees and Dependents	x100
Number of Participants with Cancer Diagnosis per 100 Eligible Employees and Dependents	Total Number of New Cases with Cancer Diagnosis / Number of Employees and Dependents Covered for the Program	x100
Percent of Participants with Cancer Diagnosis	Total Number of Participants with Cancer / Total Number of Program Participants	
Percent of Population Completing Health Assessment (HA)	Number of Eligible Employees and Dependents Completing HA / Number of Total Eligible Employees and Dependents	

Metric	Definition	Multiplier (where appropriate)
Percent of Eligible Population with Cancer Diagnosis Completing Health Assessment (HA)	Number of Eligible Population with Cancer Diagnosis Completing HA / Number of Total Eligible Population with Cancer	
Percent of Eligible Population Completing Biometric Screening	Number of Eligible Population that Completed Biometric Screening / Number of Total Eligible Population	
Percent of Eligible Population with Cancer Diagnosis Completing Biometric Screening	Number of Eligible Population with Cancer Diagnosis Completing Biometric Screening / Number of Total Eligible Population with Cancer	
Percent of Eligible Population Completing a Tobacco Program	Number that Completed the HIP Tobacco Program / Number of Eligible Population using Tobacco Products	
Percent of Eligible Population Participating in HIP Weight Management Program	Number Participating in HIP Weight Management Program / Number of Total Eligible Population	
Percent of Eligible Population Participating in HIP Physical Activity Program	Number Participating in HIP Physical Activity Program / Number of Total Eligible Population	
Percent of Eligible Population Participating in HIP Stress Management Program	Number Participating in HIP Stress Management Program / Number of Total Eligible Population	
Percent of Eligible Population Participating in HIP-sponsored Preventive Services Screenings	Number Participating in HIP-sponsored Preventive Services Screenings / Number of Total Eligible Population	
Health Coaching	Total Number of HIP Participants that Received Coaching	
Health Coaching for Cancer Participants	Total Number of HIP Participants with a Cancer Diagnosis that Received Coaching	
FML Referral	Total Number of Employees Referred from FML	
STD Referral	Total Number of Employees Referred by STD Case Managers	
STD Referral for Employees with Cancer	Total Number of Employees with Cancer Referred by STD Case Managers	
Employee/Dependent Satisfaction	Average Likert Score from Satisfaction Survey	

Creating an Evaluation Matrix

The final challenge is using the information provided in this tool to complete the evaluation matrix. Figure 2 shows an example of how to do this. The example focuses on the Access domain, and the metric is average turnaround time to provide coverage determination or prior approval of no greater than 72 hours for routine requests.

As shown in Figure 2, the evaluation objective can be measured by the medical plan. For coverage determination or prior approval turnaround time, the objective is 72 hours, and the measurement is the percent of cases that actually receive a response within 72 hours. To determine the overall average, the number of requests that receive a response within 72 hours is divided by the total number of requests. The target is to have 100% of requests receive a decision within 72 hours. The metrics provided in the "Specific Metrics for Plan Evaluation" section can be applied to the domains in this matrix.

Many objectives apply to more than one domain. The coverage determination or prior approval criteria shown here may also be used in the Satisfaction domain. As another example, the pharmacy benefit recommendation stating that the benefit plan should provide parity in copay/coinsurance for medications administered by the medical and pharmacy plan can be used in the Access and Satisfaction domains.

A similar process will have to be undertaken for each metric. Some of the measures outlined in this tool will need a baseline established in the early years of the program in order to develop objectives. For example, the total amount paid for cancer care during the first year will need to be determined in order to establish objectives for subsequent years.

Figure 2: A Sample Completed Evaluation Matrix for the Access Domain

Access Providers and Utilization Review

Objective	Measure	Target
Requests requiring Utilization Review must have an average response time of 72 hours	% of cases achieving 72-hour response ——————— Number of responses within 72 hrs/ Total number of requests	100%

These examples show how an employer can take the available information and develop a matrix. Although many metrics have been suggested, each employer will find that some apply, while others may not. In addition, it is important to note that each employer will be developing objectives based on the data received from other health care partners. In developing these objectives, all four domains described in the evaluation model (Quality, Access, Financial and Satisfaction) should be considered.

There is no "one size fits all" for developing an evaluation model and completing the evaluation matrix. The key is to build the evaluation model based on the unique needs of each organization.

Summary

This tool provides a model and the metrics needed to evaluate the performance of the vendor and the benefit plan. While evaluation can identify when objectives are being satisfactorily met, it can also identify deficits so that managers can develop targeted and focused corrective action plans. The majority of the evaluation metrics presented in this tool can be monitored regularly, allowing problems to be addressed immediately after processing the data and other information. Therefore, benefit managers are encouraged to conduct evaluations frequently and continuously to ensure that the plan is functioning as intended.

[1] Timothy J. Galpin. Making Strategy Work. San Francisco: Jossey Bass, 1997.

[2] Based on Paul R. Niven, *Balanced Scorecard*, Figure 1.4, The Balanced Scorecard, p. 14.

Tool 6:
Evaluation and Plan Reporting

A *National Business Group on Health*[SM] Toolkit

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About the National Advisory Committee on Employer Services for the Cancer Continuum of Care

The National Advisory Committee on Employer Services for the Cancer Continuum of Care serves as the expert advisory body for the *Employer's Guide*, ensuring that all information and recommendations are relevant to employers and their partners.

The Committee helps develop recommendations for the design, quality assurance, structure, and integration of resources, programs and services around the full spectrum of employer benefits and programs. This includes the health plan, health and productivity programs and health improvement programs. The Committee consists of benefit managers, clinical cancer experts, medical directors, health plan representatives, pharmaceutical representatives, health care consultants, disability managers, EAP professionals and health improvement program professionals.

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