Health Plan Quality Monitoring

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BACKGROUND

Section 1311(b) of the Patient Protection and Affordable Care Act of 2010 (ACA) detailed the intent of the federal government to establish health insurance exchanges (Exchanges) in the US states and territories. The State of Indiana is pursuing this opportunity and engaged in the planning and design phase.

The U.S. Department of Health and Human Services (HHS) and the Center for Consumer Information & Oversight (CCIO) are responsible for communication, oversight and direction related to Exchange development and qualification.

HHS has developed seven categories of principles and priorities that are used to inform potential federal funding and support of State exchanges. One of the seven principles relates to the responsibility of Exchanges to collect and publish comparative information on plan quality. That principle is provided below.

> ***"Public Accountability and Transparency*.** Accountability requires transparency. Section 1311(d)(7) requires public reports on Exchange activities, and Section 1311(e)(3) requires additional reporting, which should include standardized data reporting on price, quality, benefits, consumer choice and other factors that will help measure and evaluate performance. Successful Exchanges must ensure public accountability in areas such as objective information on the performance of plans; availability of automated comparison functions to inform consumer choice; fair and impartial treatment of consumers, plans and other partners; and prohibitions on conflict of interest."
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> (Source: The Center for Consumer Information & Insurance Oversight, "Initial Guidance to States on Exchanges")

The Affordable Care Act also describes two categories of activities for Exchanges: a) minimum functions for Exchanges and b) oversight responsibilities for Exchanges in certifying and monitoring performance of plans. Within each of those categories there are references to quality measurement and reporting. These examples are summarized below.

EXCHANGE FUNCTIONS

Core functions an Exchange must provide include:

- Assignment of a price and quality rating to plans
- Presentation of enrollee satisfaction survey results under Section 1311(c)(4)

OVERSIGHT RESPONSIBILITIES

The Secretary will develop regulatory standards that relate to quality, for:

- Accreditation for performance measures
- Quality improvement and reporting

Additional areas related to quality where Exchanges must ensure plan compliance include:

- Information on plan quality improvement activities as specified in Section 1311(g)

Given this regulatory guidance, there are significant roles and responsibilities for Exchanges related to monitoring quality measures and performance of plans and making this information available to consumers. This document provides an overview of approaches, options and resources.

APPROACHES

TYPES OF QUALITY MEASURES

State Exchanges interested in providing comparative plan quality information to consumers need to consider a range of measurement categories including:

- ***Access, availability and qualifications of the health plan's network*** – provides information to consumers on how robust and well managed a plan's delivery system is as it relates to their care needs.
- ***Member service and satisfaction with health plan experiences*** – provides both an assessment of the level of service that a health plan provides for consumers as well as a way for Exchanges to monitor qualified plan performance and identify areas of concern.
- ***Preventive care quality and adequacy*** – this category of measures provides information on how well a health plan and its network proactively ensure access to evidence-based preventive care for specific populations.
- ***Quality of chronic illness management*** – provides information on how well a health plan provides comprehensive and coordinated management of the needs of the chronically ill population.
- ***Accreditation status*** – many health plans participate in voluntary and highly respected accreditation programs through a variety of organizations including URAC and the National Committee on Quality Assurance (NCQA). In some states, accreditation or certification by one of these programs is required in order to operate certain health plan functions in that state. Accreditation or certification information provides standardized assessment of health plan functions and processes.
- ***Overall quality measurement and improvement*** – the purpose of reporting quality information is to inform consumers and incentivize health plans to improve quality. These measures focus on how well a health plan is performing in terms of identifying and addressing quality issues in health plan operations or care delivery.

The Exchange is responsible for designing or selecting quality measures, publishing those measures and explanations of what they mean, and using the information to monitor and improve plan performance. In order to ensure validity and usefulness of health plan quality measures the Exchange needs to select and use measures which meet the following criteria.

1) Measures should be evidence-based and nationally accepted approaches.
2) Measures should address a number of populations and health care concerns in order to ensure that they are comprehensive and meaningful to a diverse consumer population. Measures should address adults and children, acute and chronic care medical and behavioral healthcare, and quality of service and satisfaction.
3) The information produced should be comparable and actionable. The results should be easy for consumers to understand and interpret, and based on information that health plans and networks can use to improve performance.
4) The data used to create the measures should be from sources that are common in health plan operations (such as claims data) and standardized for easy comparison.
5) Stakeholders and health plans should be involved in the selection and discussion of how measures will be produced and used in the Exchange.
6) The measures should be created and managed in a dynamic fashion which will allow Exchanges to adjust the measures in the future in response to improvements in measuring and impacting quality, as well as experience with consumer use of the information.

SOURCES OF QUALITY INFORMATION AND MEASURES

The data sources that are commonly used for quality measurement in health plans include claims data, medical record information, and consumer surveys and assessment tools. Claims data based measures are most common because of the ease of standardizing the measures and calculations, as well as the universal availability of this type of data. Medical record data may be used to augment claims data, as it is in select NCQA Healthcare Effectiveness Data and Information Set (HEDIS®) measures, or to conduct focused studies. Medical record data, even in environments where there are electronic medical records, is expensive to use in large scale measurement and lacks consistency in coding and use of terms. Medical record data can be very useful in targeted studies or special investigations where specific quality concerns are being evaluated. Consumer surveys and tools may include assessments of member satisfaction as well as tools that evaluate member health and function levels. Health plans may use a variety of tools with the most common standardized tool being the Consumer Assessment of Healthcare Providers and Systems (CAHPS®).

Exchanges may elect to use quality measures that are already produced by other organizations or the Exchange may collect data and internally produce the measures and comparisons. One commonly used source of health plan information are organizations that accredit, certify and report on plan performance. There are several organizations involved in accrediting health plans but two of the most well-known are NCQA and URAC. These organizations and their involvement in Exchanges and other state-based initiatives is summarized below.

- ***National Committee for Quality Assurance***
  NCQA is a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality. NCQA was founded in 1990. NCQA accredits health plans in every state, the District of Columbia and Puerto Rico. These plans cover approximately 70 percent of all Americans enrolled in health plans. NCQA also administers the Healthcare Effectiveness Data and Information Set (HEDIS), which is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service as well as the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) health plan survey. (Source: www.ncqa.org)

  NCQA offers a range of programs including: accreditation, certification, recognition, distinction and evaluation options that encompass assessment of areas such as overall health plan operations and quality, disease management, wellness, diabetes, and patient centered medical home.

  The NCQA website publishes health plan accreditation status as well as a star-rating system of categories within the accreditation program. These star ratings and the HEDIS and CAHPS® results are used by states and government agencies to publish comparative information about health plans and quality programs.

- ***URAC***
  URAC, is an independent, nonprofit organization, and a well-known as a leader in promoting health care quality through its accreditation, education and measurement programs. Operating for over 20 years, URAC has over 25 accreditation and certification programs. (Source: www.urac.org)

URAC currently provides the accreditation status of health plans and programs on its website. Both the accreditation of the organization as well as the level of status are reported. In addition, regulators can request a detailed report from URAC regarding the accreditation scores and status of health plans in their region. URAC provides most states with quarterly reports of health plans in their states and these reports can be used free of charge to produce and publish health plan scores. URAC has also developed customized programs and measures for states such as Ohio, Texas and Florida. In Florida, URAC has developed a measurement and auditing program that is used by the state in response to quality concerns about certain types of outpatient clinics. In North Carolina, URAC developed a measurement and monitoring program for the state in response to concerns about quality in group homes funded by the state.

URAC is developing a quality measurement system to be released over the next several years. The quality measurement system will address case management and pharmacy management as well as overall health plan operations.

PUBLISHING QUALITY SCORES

One of the key roles of Exchanges is to publish consumer friendly health plan quality measures. The information should be provided in a manner that allows consumers to easily understand and compare health plan performance so that they make an informed decision when selecting a plan option. The information is also expected to be used by the Exchange to monitor, manage, and certify qualified health plans.

Organizations that publish quality information and rankings for consumers may elect to publish actual measure results, a comparative level of performance rating (such as star rating systems) or a combination. Two examples of government agencies that publish quality data include the CMS Medicare Advantage program and the Massachusetts Health Connector.

- **CMS Medicare Advantage Plan Quality Reporting**

  CMS provides consumers a five-star quality rating system on health plan performance on their consumer website. The five-star quality scores for Medicare Advantage plans are derived from four sources:

  1) CMS administrative data on plan quality and member satisfaction,
  2) The Consumer Assessment of Healthcare Providers and Systems (CAHPS®),
  3) The Healthcare Effectiveness Data and Information Set (HEDIS®), and
  4) The Health Outcomes Survey (HOS).

  The individual measures and the scores comprising the summary score are adjusted for "skewness" to avoid a clustering of scores at either the high or low end. The individual measures are also adjusted for patient characteristics, to make the survey results more representative of all beneficiaries enrolled in Medicare Advantage. CMS does not publish quality ratings for a plan if the data is incomplete. (Source: Kaiser Family Foundation "What's in the Stars?", Gretchen Jacobson, Anthony Damico, Tricia Neuman, and Jennifer Huang, December 2009).

- **Massachusetts Health Connector**

  The Massachusetts Health Connector provides insurance carrier four-star ratings based on NCQA categories of measures including:

  - Overall quality
  - Access and service
  - Qualified providers
  - Staying healthy
  - Getting better
  - Living with illness

Plan scores are presented using a four-star rating system.

OPTIONS AND COSTS

The Indiana Health Insurance Exchange has several options for publishing quality information. Those options, resource components and relative costs are summarized below.

Option One – Use Existing Quality Measurement Sources

Advantages and Disadvantages

This approach uses existing nationally recognized sources of quality information such as NCQA or URAC to publish comparative health plan quality rating information. The advantage is that this information is nationally accepted, standardized, and a common and tested source of comparative information. The disadvantage is that not all health plans will participate in one or both of these organizations and some of the smallest and most at-risk health plans may not have publishable information.

Resource Requirements and Costs

This approach will require the Exchange to have expertise in understanding these sources and developing processes for routinely acquiring and publishing the information on the Exchange site.

This option is relatively low cost in that the national organizations do not charge for the results and are proactive in wanting to work successfully with Exchanges. Consequently, they provide a significant amount of in-kind assistance in providing the information. The costs that the Exchange will need to account for include stakeholder facilitation and decision-making on the measures, acquisition and publication of the measures, and maintenance of the website.

Option Two – Exchange Produces the Quality Measurement Sources

Advantages and Disadvantages

Under this approach the Exchange would design and produce the quality measures based on a variety of information sources. This approach may use a blend of existing nationally recognized sources of quality information (NCQA, URAC, AHRQ measures) along with measures produced from Exchange required data sources. The advantage to this approach is that it can result in information on every health plan and more specific information than accreditation status or star ratings. The disadvantages are the time and resources required to design and publish credible measures. The

Exchange also takes on additional liability if it becomes a unique producer of quality results. This option may be more suited for later phases in Exchange implementation after gaining experience publishing and analyzing health plan quality data.

Resource Requirements and Costs

This approach will require significant resources. The Exchange would have to conduct a number of stakeholder sessions including quality measurement experts in order to reach agreement and some level of acceptance of quality measures that are to be published and used. The Exchange would then need to develop technical requirements and data source and publishing resources, potentially including development of capabilities such as data marts and analytic tools and models.

This option is high cost with the need to hire measurement expertise and conduct stakeholder sessions in the design phase. The production phase would require full-time staff who write and maintain measurement and technical requirements as well as information technology and analyst staff that produce the measures. The Exchange would also need to purchase legal, contracting and risk management expertise to address liability concerns.

Mandatory – Quality Information Monitoring and Management

Exchanges are required to develop health plan quality monitoring and management capabilities. This is a valuable function that requires planning and investment. The Exchange should develop several areas of expertise and service related to this requirement:

- ***Measurement selection and maintenance*** – the Exchange may elect to use consultant or contracted resources initially to assist in selection, design and deployment of the measures. Once measurement approaches are established, Exchange staff will be able to maintain the measures.
- ***Analysis of results*** – the Exchange should establish routine processes for analyzing health plan performance. Again, the process development could be designed using consulting or contracted staff with the analytic work managed by Exchange staff. The type of resources required would be data analysts with health care experience and oversight by personnel with clinical quality and health plan expertise.
- ***Intervention and management of performance*** – the Exchange will need to develop mechanisms for intervening in cases of poor or declining performance. Initially, the Exchange will need to develop processes and procedures for intervention. This will require staff with quality measurement and performance improvement expertise.
- ***Customer service*** – the Exchange may want to consider building the capability to address consumer questions on what the measures mean and how to use the information. This may require educational materials and other forms of consumer support.