DATA AVAILABILITY FOR PROPOSED QUALITY RATING SYSTEM MEASURES

Looking forward to the Exchange’s future open enrollment periods in years beyond 2013, a set of 74 measures for inclusion in the Quality Rating System (QRS) has been proposed to the Measurement and Reporting Work Group. This memo begins to address the practical issues with implementing the proposed QRS by summarizing the current availability of data across Minnesota carriers and suggesting strategies for data collection when data for proposed measures are not currently available.

Data Currently Available

**HEDIS/CAHPS**

The proposed measures in the QRS draw heavily on measures that are publicly reported by NCQA’s Plan Rankings and by Consumer Reports, an indication that these organizations consider them not only relevant to plan quality but suitable for consumer reporting. In fact, 52 of the 74 proposed measures (70%) are measures used in the Plan Rankings.

As previously mentioned when discussing options for reporting quality information in October 2013 Open Enrollment, the carriers that account for 88 percent and 96 percent market share, respectively, of Minnesota’s individual and small group markets are currently included in NCQA’s Plan Rankings system. There are several HEDIS/CAHPS measures in the proposed QRS outside of the Plan Rankings measures but also currently available in Minnesota as indicated by commercial carriers in response to a request for information from the State. These include measures such as Ambulatory Care, Inpatient Utilization – General Hospital/Acute Care, Mental Health Utilization, Adults’ Access to Preventive/Ambulatory Health Services, Plan All-Cause Readmissions, Plan Information on Costs, Shared Decision Making, and the Relative Resource Use measures. Considering these measures, we expect that at least 82% (61 measures) of the proposed measure set is already being collected by plans with most of the current market share in Minnesota. Thus, we expect significant consistency in currently available commercial data, as existing carriers that may potentially offer QHPs in the Exchange will already have systems in place to collect HEDIS/CAHPS data.

Carriers that do not have systems in place to collect HEDIS/CAHPS data will need to begin preparing to collect, calculate, and submit such data. Because plans need at least one full measurement year to report on performance, all carriers will need to set up the administrative processes to begin data collection in 2015 for any measures that will be reported at the QHP level, based on service and care for enrollees in 2014. This will include both the clinical (HEDIS) measures and the patient experience (CAHPS) measures.

As federal regulations require QHPs to be accredited on performance in nine categories, two of which are clinical quality measures such as HEDIS and patient experience results, the proposed measures for the QRS will largely overlap with the QHP accreditation requirement. This consistency in requirements

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2 42 CFR § 156.275
will decrease the data collection burden on plans, particularly for new market entrants that may not already collect this type of information.

**Data Not Currently Available**

The 13 measures that make up the remaining 18% of the proposed QRS are taken from a few different measure sets:

*eValue8*

The largest subset of measures in the Rating System not addressed by HEDIS/CAHPS is the National Business Coalition on Health’s (NBCH’s) eValue8 measure set. The eValue8 Request for Information is a standard RFI tool that helps purchasers to identify high performing plans, not only in the areas of clinical care, but also in the plan management, programs, and services that promote chronic disease management, pharmaceutical management, consumer engagement, provider measurement, and prevention of disease. The RFI is intended to capture plan features that contribute to a value-based system, providing a more comprehensive review of plan quality than use of the HEDIS/CAHPS measures alone.

In 2010, 13 state or regional health coalitions participated in the eValue8 process, supporting the RFI for health plans and offering purchasers comparative quality and value information. State Exchanges are currently considering the use of eValue8. In California, QHPs are required to complete the RFI to qualify for Exchange participation. In Washington State, the Exchange is considering ways to include eValue8 results into its Consumer Rating System. In 2007, three leading carriers in Minnesota took part in the eValue8 process. In fact, a local business coalition, the Minnesota Health Action Group, participated on the team that first developed the eValue8 tool. The Exchange could reinstate the eValue8 process in Minnesota with local partners in order to have an eValue8 process in place by the end of 2013. Then, the first health plan Request for Information could begin in early January 2014 so that data could be collected for reporting as early as the October 2014 Open Enrollment period.

**Cultural Competency Measure**

RAND’s Cultural Competency Implementation Measure is a survey measure completed by carriers. It was recently endorsed by NQF as part of an initiative to endorse measures that address health disparities. It is a relatively new measure and not in current use by Minnesota carriers; however, the survey is a quick way to collect information from carriers on how well they are providing culturally competent care. The survey instrument is meant to take about 30-40 minutes to answer and the results identify the degree to which an organization has implemented 12 NQF-endorsed cultural competency practices. This places

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limited burden on carriers to complete the survey, but provides highly desired information on the carrier’s activities related to cultural competency.

**Network Adequacy Measures**

In response to the work group’s desire to have more network adequacy measures represented in the QRS, the proposed measure set includes two measures that are mandatory for URAC accreditation. They are not included in the HEDIS/CAHPS data set and currently are not calculated by commercial health plans in Minnesota. URAC derived these two measures from the Centers for Medicare & Medicaid Services’ (CMS’s) reporting requirements for Medicare Part C plans. The network adequacy measures are designed to assess the number of specialists and primary care providers accepting new patients at the end of the reporting year, stratified by provider type and zip code. As carriers currently should be keeping track of this information for providers in the network, the main barrier to collection of these measures will be the programming necessary to perform the counts. If the Exchange decides to move forward with these measures, it may wish to use URAC’s technical specifications or design its own. For example, the Exchange might want to tailor the measure to define what provider types are considered primary care and what specialties get included in the specialist measure.

**Dehydration Admission Rate and HIV/AIDS Visit Measures**

Two measures remain in the proposed QRS that are not addressed by the above collection strategies. These are Dehydration Admission Rate and HIV/AIDS Medical Visit, as recommended by NCQA for health insurance exchange consumer reporting.

The Dehydration Admission Rate measure is an NQF-endorsed measure that is part of the AHRQ Ambulatory Care Sensitive Conditions measure set currently in use by the MN Department of Human Services (DHS) for evaluation of Medicaid plans. Although the data are collected via hospital discharge records, the measure is a Prevention Quality Indicator (PQI) that indicates how well fluid status is monitored in an outpatient setting, particularly for those with comorbid conditions, the elderly, and the very young. Data for this measure can be obtained through a query of administrative claims records.

Another clinical measure is HIV/AIDS Medical Visit, which has been recommended by NCQA due to the national prevalence of HIV and the disproportionate burden of disease on people of color. It represents how well care is coordinated for people with HIV through a hybrid data collection methodology.

Both the Dehydration Admission Rate measure and the HIV/AIDS Medical Visit measure can be obtained through similar processes already in place to collect HEDIS clinical measures.

**Summary and Discussion**

Overall, the proposed data collection efforts necessary for the recommended QRS measure set overlap substantially with other Exchange requirements, such as QHP accreditation and the enrollee satisfaction survey. In addition, the majority of proposed measures are HEDIS/CAHPS measures, which most carriers in Minnesota already collect. Given these two factors, the time and cost required to submit data for use in the QRS should not be unreasonable for carriers wishing to participate in the Exchange. The largest proposed new data collection effort would be the eValue8 RFI, which should be a relatively cost-effective and valuable addition to health plan quality information, particularly if it is also supported by other Minnesota partner organizations.

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Discussion Questions:

• To what extent does the proposed Quality Rating System measure set align with the Work Group’s principle that the QRS should build on existing data sources where possible?

• If the Exchange moves forward with using the full range of measures proposed for the Quality Rating System, would data collection efforts associated with these measures be reasonable for both existing carriers in the individual and small group markets as well as new entrants for purposes of the Exchange?