A set of 74 measures for inclusion in a future Quality Rating System (QRS) has been proposed to the Measurement and Reporting Work Group (MRWG). This memo will summarize the expected time frames for when data may begin to be collected for the 74 proposed measures. These time frames may influence decisions around timing of data collection requirements and whether or not to report a subset of the proposed measures in the initial years of MNsure operation before it is possible to collect and report on all measures.

Please refer to the accompanying spreadsheet that provides detail on all 74 measures organized by composite. This spreadsheet gives the measure definition, as well as information about the length of time a consumer needs to be enrolled in a QHP before that consumer’s care experience can be measured (“continuous enrollment requirements1”), the first time data collection would be possible given the measure definition and continuous enrollment requirement, and consequently when the data could be reported in the QRS.

This memo also anticipates challenges for measurement associated with potential changes in the inventory of QHPs offered on MNsure each year and recommends a strategy for addressing these issues.

**Measures Potentially Available for Reporting during 2014 Open Enrollment**

Coverage will become available in January 2014 for consumers enrolling in qualified health plans (QHPs) offered on MNsure. Data for most of the proposed QRS measures cannot be collected for QHPs until members have been enrolled in Exchange QHPs for at least one year.

- The majority of proposed QRS measures are HEDIS measures that require at least one year of enrollment before data collection can begin. Thus, data based on Exchange enrollee experience for these measures would not be available during 2014 Open Enrollment.
- The eValue8 measures and Cultural Competency Measure provide consumers with information on the availability of plan programs and services that improve the quality of the plan. Since

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1 Please note the phrase “continuous enrollment requirement” refers only to length of enrollment required for purposes of health plan quality measurement.
many of these measures report on plan structure, there is no restriction on how long members have to be enrolled in order to collect this information.

• The URAC provider network adequacy measures could also be reported during 2014 Open Enrollment, as these measures only require data from one point in time. The number of providers accepting new patients could be pulled right before 2014 Open Enrollment to most accurately reflect availability of providers at the time of QHP enrollment.

Measures Potentially Available for Reporting during 2015 Open Enrollment

• About half of the proposed measures (36 measures total) could be reported during 2015 Open Enrollment. For most HEDIS/CAHPS measures, the look back period is one measurement year and members must be continuously enrolled during the measurement year with no longer than a 45 day gap. This includes all of the CAHPS measures proposed in the QRS, which contribute to the QRS sub-composites What Members Say about their Health Care, Quality of Customer Service and Claims Processing, and Access to Quality Health Care.

• There are many other sub-composites that will have reportable individual measures in 2015, such as Diabetes, Heart Disease, Mental Health, Adults Staying Healthy, Children Staying Healthy, and Other Tests and Treatments. Of these, only two sub-composites (What Members Say about their Health Care and Diabetes) would be able to report all individual measures that comprise the sub-composite in 2015 (in addition to Plan Programs and Information to Help Members Get Better and Stay Healthy which is potentially available for 2014 Open Enrollment reporting). For the other sub-composites, there would be a range of “completeness.” For example, one out of five measures will be available for Heart Disease while five out of seven measures will be available for Access to Quality Health Care.

• There are only two sub-composites in the QRS that would have no potential individual measures in 2015: Child and Adolescent Health and Mother and Baby Staying Healthy.

Measures Potentially Available for Reporting during 2016 and 2017 Open Enrollment

• For 2016 Open Enrollment, 96 percent of the proposed measure system could be reported and all but three of the sub-composites will have complete measure sets. There are only three measures in the proposed measure set that require enrollment in both the measurement year and two years prior to the measurement year: Use of Spirometry Testing in the Assessment and Diagnosis of COPD, Cervical Cancer Screening, and Adults’ Access to Preventive/Ambulatory
Health Services. These measures contribute to the sub-composites Other Tests and Treatments, Adults Staying Healthy, and Access to Quality Health Care.

- The entire proposed QRS could be reported on for 2017 Open Enrollment.

Timing of Data Collection Requirements and Public Reporting of Measures

The Exchange has several options for addressing issues associated with when data may begin to be collected and publicly reported:

1) The Exchange may collect data on measures proposed for inclusion in the QRS based on pre-Exchange enrollee experience and calculate composites based on pre-Exchange enrollee experience. Over the initial years of MNsure operation, data would evolve to include both pre-Exchange and Exchange enrollment until sufficient time had passed to include only Exchange enrollee experience.²

Advantages:

- This approach would provide consumers with quality data in a more timely way as compared to other approaches.

Disadvantages:

- Initially, these data would not be based on MNsure enrollee experience.

Alternatively, MNsure could instead continue to report using existing market data until data including MNsure enrollee experience is available.

2) The Exchange may phase in data collection requirements as it becomes feasible for carriers to collect data on MNsure enrollee experience given individual measure specifications and continuous enrollment requirements.

Advantages:

- Collection and reporting of data on subsets of measures will provide data on quality based on Exchange enrollee experience to consumers as it becomes available.

² A potential alternative to collecting data at the Exchange product type level would be to collect at the product type level both inside and outside the Exchange. Should MNsure collect data at this level of aggregation, data would include both Exchange and non-Exchange enrollees.
Disadvantages:

• Reporting on subsets of measures, however, will provide a more limited view into health plan performance as compared to the full range of measures identified as integral to plan quality. For example, should Adults Staying Healthy measures be reported during 2015 Open Enrollment if only two of the nine measures (Flu Shots and Chlamydia Screening) are available?

3) The Exchange may wait to collect and report data until 2015 or 2016 when data for the vast majority of measures and/or sub-composites would be available for reporting based on Exchange enrollee experience. Although various measures based on Exchange enrollee experience have the potential to be collected and reported in the first one to two years of Exchange implementation, it may be desirable to begin implementation at a point when more measures can be collected and reported. For example, the only possible composite in 2014 is Plan Programs and Information to Help Members Get Better and Stay Healthy. In 2015, however, about half of the measures that make up the proposed QRS could be collected.

Advantages:

• This option aligns with the U.S. Department of Health and Human Services’ intention not to enact reporting requirements until 2016\(^3\);

Disadvantages:

• This approach significantly delays the opportunity to provide consumers with a substantial amount of Exchange-level quality information. Option One (reporting on quality at the carrier product-level, rather than solely on Exchange enrollee experience,) could be utilized during this period of delay.

There are advantages and disadvantages to each of these approaches. If reporting measures would be feasible but delayed while awaiting a broader set of measures, then requiring carriers to collect the data for the feasible measures could also be delayed, thus reducing data collection burden on carriers and

allowing them more time to prepare for future years of data collection. Alternatively, data collection for all feasible measures could be required, even if not publicly reported, so that both carriers and the Exchange can test the collection and transfer of data before it is used for public reporting. Collecting the data for periods for which measures will not be publicly reported also allows the Exchange to analyze the measures for variation among plans and potential sample size issues that may influence the decision to publicly report in future years.

**Calculating composites using a subset of measures in the QRS**

Since the full set of proposed measures would not be available for reporting based on Exchange enrollee experience until 2017, the composite methodology would have to account for these year-to-year changes if the Exchange decides to proceed with a phased in approach to collection and reporting of quality measure data (consistent with Option Two and Three described above). There are several ways to handle this evolution in the QRS:

- Do not calculate composites until 2017. This would not be recommended, as composites quickly summarize quality information for consumers rather than consumers having to digest many individual measures.
- Only calculate composites when all measures are available for reporting. Under this method, most sub-composites (9 of 12) would be reportable by 2016. Only two sub-composites would be reportable in 2015. This same methodology could be applied to higher level composites.
- Calculate composites that meet a threshold of composite “completeness.” Similar to the issue of missing data, composites could be reported if half (or some other designated proportion) of the individual measures that make up the composite are available. Under this method, all sub-composites would be reportable by 2016 and most (8 out of 12) would be reportable by 2015. This same methodology could be applied to higher level composites.

Regardless of the option for compositing chosen above, consideration should be given for providing consumers with some type of overall quality score, even if calculating an overall “Quality of Health Plan” composite does not yet make sense given the available individual measures. One potential overall quality measure that does not require compositing is use of the CAHPS *Overall Rating of Health Plan* measure (available for reporting in 2015 Open Enrollment) which is already a proposed measure in the QRS.
Evolution of QHPs over time

It is expected that, especially in the first few years of the Exchange, QHPs will enter and exit the market depending on their success and enrollment. If reporting is required at the QHP level, then any new QHP that enters the Exchange marketplace after the 2013 Open Enrollment period will be missing more measures than QHPs that have existed longer, given the measure availability timeframe discussed above. Reporting at the Exchange product-level, rather than the QHP-level, will help mitigate this missing measure issue. By reporting at the Exchange product-level, carriers that have previously offered QHPs on the Exchange can immediately report quality information for new QHPs in an already-reportable product line. There will still be missing data if new carriers offer a QHP in the Exchange, but at least it facilitates reporting of data for those carriers already participating in MNsure. Previous MRWG feedback has expressed preference for data collection at the Exchange product-type level, and the variation in timing of measure availability for reporting in the QRS lends support to this approach.

If missing data for new carriers coming into MNsure after 2013 is a concern, then requiring carriers to report measures for the carrier product level (inclusive of both Exchange and non-Exchange enrollees) may be preferable. The advantages and disadvantages of this approach are outlined in Option One of the Timing of Data Collection Requirements section of the memo.

Discussion Questions

- Do the potential advantages associated with earlier data collection and public reporting of data outweigh the potential disadvantages of collecting and reporting data on only a subset of measures during the initial years of Exchange implementation?

- What compositing option should be utilized if only a subset of individual measures is available? If a composite is not available, should another overall quality score be used?

- What other issues should MNsure consider in determining the implementation timeline for MNsure’s quality rating system?