



The Minnesota Health Insurance Exchange will begin its first open enrollment period in October 2013. The Exchange has several options related to public reporting of quality data related to qualified health plans (QHPs) available on the Exchange for the October 2013 open enrollment period.* By necessity, any quality data published in October 2013 will be based on carrier and consumer experience in the marketplace prior to the launch of the Exchange. This memo outlines the options for reporting pre-Exchange carrier quality data for consumer use during Minnesota's 2013 open enrollment period. These options include:

- Reporting no quality information for participating carriers.
- Reporting some quality information that is currently being collected by at least some carriers in Minnesota. Four different variations of this option are presented and discussed, including use of solely CAHPS data, use of NCQA's Accreditation Report Card, use of NCQA's Health Insurance Plan Rankings, or a strategy that would use both CAHPS and disaggregated HEDIS measure data.

The discussion that follows outlines advantages and disadvantages of each option with the primary considerations being usefulness to consumers and feasibility of implementation for both carriers and the Exchange. The Exchange is seeking Measurement and Reporting Work Group member input on which option to pursue for the October 2013 open enrollment period. The Exchange recognizes that a choice to use one of the options presented in the memo will require further analysis and decisions related to how the data may be presented and other reporting issues.

The overall context for decision-making is the Exchange's recognition that giving consumers information on carrier quality along with other basic information about QHPs will help consumers to choose plans that will best meet their needs and preferences. Such informed consumer choice can also create marketplace leverage to drive continuing improvement in the quality and efficiency of plans and the overall value delivered by the health care system.

Option 1—Do not publish quality data in 2013

While the Exchange will be required to implement a quality rating system and publish information on enrollee satisfaction by 2016, those federal requirements are not effective for the October 2013 open enrollment period. Although reporting on plan quality is generally desirable, there are two primary reasons to consider not reporting quality measures for 2013 open enrollment: lack of complete consistency across carriers with regard to currently available data and that data would not yet be based on Exchange market experience.

The Exchange does not yet know which carriers will seek to offer qualified health plans on the Exchange, which makes it challenging to fully assess the extent of consistent reporting activities

* Considerations for development of a quality rating system for future years will be addressed in other memos. This memo focuses solely on options for quality data for the October 2013 open enrollment period.

across carriers that will ultimately participate in the Exchange. Some carriers that may wish to participate in the Exchange may not currently report data that are comparable to the measures other plans have. This may be because some carriers are serving only Medicaid and/or Medicare enrollees, while other carriers are in the private commercial market. In addition, other carriers not currently doing any business in Minnesota may seek to do so and participate in the Exchange. Even insurance companies currently in the Minnesota commercial market may not be collecting these data as they are not required to do so.

Advantages of Option One

- For carriers that have simply not collected appropriate measures, the time is short to do so now for 2013 open enrollment. With limited exceptions to be discussed further in this memo, carriers that do not currently report quality data have no way to collect and submit these data prior to the October 2013 launch of the Exchange.
- Carriers for which quality data are not available in the 2013 open enrollment period may be at a disadvantage on the Exchange marketplace. It is possible consumers may be less interested in choosing a plan offered by a carrier with no quality information if other carriers offer plans that do have quality data associated with them. The prospect of such an effect may discourage carriers from participation in the Exchange market.
- Currently available data do not reflect experience in the Exchange.

Disadvantages of Option One

- There is a substantial amount of quality data available for carriers currently serving almost all of the individual and small group market. The Exchange would lose a significant opportunity to provide quality information to consumers during its inaugural open enrollment period despite a reasonably consistent base of existing data. Without quality data, consumers will make choices based solely on cost information.

Options for Publishing Quality Data in 2013 Based on Data Currently Reported by Carriers

There is a considerable assortment of quality measures already being collected and reported by the major carriers in Minnesota, with significant similarities in data reporting activities among these plans. The Exchange could choose to report some or all of these existing data.

Option Two: Reporting on CAHPS Health Plan Survey Results

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) health plan member survey developed and maintained by the U.S. Agency for Healthcare Research and Quality (AHRQ) is a widely used tool, endorsed by NQF, to measure member experiences with their health plan. It is used to evaluate many commercial and Medicaid health plans in Minnesota, with many of the same questions used for both the commercial and Medicaid product lines. Currently, the CAHPS Health Plan Adult questionnaire is used in evaluating plans for NCQA accreditation, and the Medicaid version is used for Medicaid HMO plans as the Minnesota Managed Care Public Programs Consumer Satisfaction Survey.

Current Data Availability

Among private commercial plans, four carriers (Blue Cross Blue Shield, Medica, Health Partners, and Preferred One) that account for roughly 88 percent of the state's individual market and about 96 percent of Minnesota's small group market (according to 2011 Minnesota Department of Health's Health Economics Program "Chartbook" statistics on health plan market share) have CAHPS survey results for 2012 from surveys of commercial enrollees. Sanford Health Plan, which has a smaller share of individual or small group commercial enrollment in Minnesota, also has CAHPS survey results from commercial enrollees. In addition, all Medicaid managed care organizations in Minnesota must participate in the managed care satisfaction survey using the CAHPS survey, and results are publicly reported by the state for eight plans in 2012 (Blue Plus, HealthPartners, IMCare, Medica, Metropolitan, PrimeWest, South Country Health Alliance, and UCare).

The federally-facilitated exchange intends to display existing CAHPS results from accredited commercial and Medicaid product lines until QHP-related ratings are available for 2016 open enrollment¹.

What is being Measured

The CAHPS Health Plan Survey Adult Questionnaire addresses multiple facets of the health plan member experience, including, as shown in the left column of Figure 1 below:

- Rating of Health Plan;
- Rating of Health Care;
- Rating of Personal Doctor;
- Rating of Specialist;
- Getting Needed Care (a composite);
- Getting Care Quickly (a composite);
- How Well Doctors Communicate (a composite);
- Health Plan Customer Service (a composite); and
- Claims Processing (a composite applicable to commercial product lines only).

These measures can be calculated and reported in various ways. One calculation option is percentages, or proportions, of members selecting a certain response option. For example, it might be the percentage of respondents who rated the plan 9 or 10 on a 0-10 scale or it might be the percentage who report that the plan's customer service was "always" helpful and courteous. Alternatively, the scores can be calculated as means after assigning a numeric value to each response scale option. Some questions are combined into composite scores, as listed above. The scores can be adjusted to take into account the plan's case mix (unique demographic profile of the plan's membership that is outside of the plan's control) and the inherent tendency of various member segments to rate more or less favorably (for example, older respondents tend to give higher scores). Scores can be standardized using percentiles, number of standard deviations from the all-plan mean, or other methods. And whatever the resulting score, it can be represented as a number, a symbol, a word, or a bar graph, or in some other way.

Two specific options would be either to use NCQA's methodology for constructing a Consumer Satisfaction score, which includes various CAHPS questions, or to use the single "Rating of Health Plan" question. The Consumer Satisfaction score is an average of nine CAHPS measures (either ratings on individual questions or composite measures based on two or more questions), each standardized and weighted equally. The left column on Figure 1 shows for one plan the Consumer Satisfaction score and the ratings questions and composites that make it up.



NCQA's Health Insurance Plan Rankings 2012-2013 – Private Plan Details



Plan name : HealthPartners - HMO/POS
 Ranked 28
 URL: http://www.healthpartners.com
 Overall Score : 87.6
 States : MN, WI
 NCQA Accreditation: Yes

Consumer Satisfaction (4)	Prevention (4)	Asthma (5)	Treatment (5)
Getting care (3)	Children and adolescents (4)	Asthma (5)	Mental and behavioral health (5)
Getting care easily (3)	Well-child visits, infants (3)	Medicate asthma appropriately (5-11 years old) (3)	Depression—adhering to medication for 12 weeks (5)
Getting care quickly (3)	Well-child visits, ages 3-6 (3)	Medicate asthma appropriately (12-18 years old) (4)	Depression—adhering to medication for six months (5)
Satisfaction with physicians (4)	Access for children ages 7-11 (3)	Medicate asthma appropriately (19-50 years old) (4)	Follow-up after hospitalization for mental illness (4)
How well doctors communicate (4)	Adolescent well-care visits (2)	Medicate asthma appropriately (51-64 years old) (4)	Alcohol or drug dependence treatment initiated (2)
Rating of personal doctor (3)	Early immunizations (3)	Diabetes (5)	Alcohol or drug dependence treated for 30 days (3)
Rating of specialists (3)	Adolescent immunizations (4)	Blood pressure control (140/90) (5)	Follow-up after ADHD diagnosis (4)
Rating of care received (3)	BMI percentile assessment (4)	Blood pressure control (140/90) (5)	Continued follow-up after ADHD diagnosis (3)
Satisfaction with health plan services (3)	Nutrition counseling (3)	Retinal eye exams (4)	Other treatment measures (5)
Handling claims (3)	Physical activity counseling (3)	Glucose testing (5)	Use of aspirin (3)
Rating of health plan (3)	Women's reproductive health (4)	Glucose control (5)	Appropriate antibiotic use, adults with acute bronchitis (3)
Customer service (4)	Timeliness of prenatal checkups (3)	LDL cholesterol screening (5)	Appropriate testing and care, children with pharyngitis (5)
	Postpartum care (3)	LDL cholesterol control (5)	Medication for rheumatoid arthritis (5)
	Cancer screening (4)	Monitoring kidney disease (4)	Monitoring key long-term medications (4)
	Breast cancer screening (4)	Heart disease (5)	Steroid after hospitalization for acute COPD (5)
	Cervical cancer screening (4)	Beta blocker after heart attack (3)	Bronchodilator after hospitalization for acute COPD (3)
	Colorectal cancer screening (4)	Controlling high blood pressure (5)	Testing for COPD (5)
	Other Preventive Services (5)	LDL cholesterol screening (3)	Appropriate antibiotic use, children with URI (4)
	Adult BMI assessment (5)	LDL cholesterol control (5)	Appropriate use of imaging studies for low back pain (5)
	Chlamydia screening (4)		
	Flu shots for older adults (4)		

Figure 1 – NCQA Plan Rankings for a single plan (customer satisfaction data in left-hand column)

Advantages of using the overall Consumer Satisfaction score

- The Exchange would leverage an existing, vetted methodology for aggregating data on a broad range of topics related to consumer satisfaction into a single summary result, and consumers could be given the option to “drill down” and obtain data on each of the components contributing to the overall score.

Disadvantages of using the overall Consumer Satisfaction score

- The Exchange would need to confirm with NCQA that it is permissible to use NCQA’s calculated results.
- The Consumer Satisfaction score is only available for plans that conduct the CAHPS survey and report results to NCQA.
- By combining several aspects of plan performance into a single overall satisfaction score, this measure tends to reduce variation in reported plan quality. More variation is present at more granular levels, including the overall Rating of Health Plan question, and consumers would likely find information on such variation of interest.
- The Consumer Satisfaction score for commercial plans includes claims processing while the Consumer Satisfaction score for Medicaid plans does not. This may be an issue if the Exchange reports Medicaid CAHPS data for carriers lacking CAHPS data for commercial enrollees as described as an option later in this document.

Advantages of using only the CAHPS “Rating of Health Plan” question

- This is information that is familiar to carriers and is often used for public reporting.
- Results could be reported for plans that conduct the CAHPS survey and choose not to report the results to NCQA. There are no potential issues related to recalculating the score.
- There tends to be more plan-to-plan variation in this score than there is in the composite Consumer Satisfaction score calculated using NCQA’s methodology.

- There is Medicaid CAHPS information that is directly related to this same question, which would be helpful if the Exchange reports Medicaid CAHPS data for carriers lacking CAHPS data for commercial enrollees, as discussed later in this document.

Disadvantages of Using only the CAHPS “Rating of Health Plan” question

- It is a single measure and does not show members' judgments broken down by underlying dimensions of plan quality.
- It is possible that survey respondents' opinion of their plan may be influenced by the cost of that plan when the primary goal of the quality rating system is to consider quality.

Other considerations in using CAHPS data

Some carriers that may wish to offer QHPs in the Exchange do not currently have CAHPS scores from enrollees in the commercial market. Two courses of action would potentially broaden the base of available CAHPS data:

- Should the Exchange decide to publish CAHPS data on the Exchange for the October 2013 open enrollment period, the Exchange could convey that decision clearly to all carriers potentially interested in offering QHPs. Carriers currently serving the commercial market but not already collecting these data could act quickly to do so prior to the October 2013 open enrollment period. In addition, carriers that have commercial enrollment in other states and wish to participate in the Exchange could be invited to provide their survey results from other states or to do surveys of their members in other states. (For carriers not currently doing surveys and reporting the results to NCQA, it would likely be challenging to complete the survey soon enough and get the overall Consumer Satisfaction score calculated using NCQA's methodology in time for October 2013 open enrollment reporting; just reporting the results on the single Rating of Health Plan question would be more readily feasible.)
- Another strategy for broadening the base of available data would be to use results of CAHPS surveys of Medicaid enrollees for the 2013 open enrollment period for carriers that are having such surveys done as required by the Minnesota Department of Human Services. The Medicaid survey has many of the same questions as the commercial survey, including the questions on overall “Rating of Health Plan” and “Rating of Health Care.” It does not have a few of the questions, such as questions on claims handling.

A consideration in use of Medicaid CAHPS data is that results on a Medicaid survey might not be a good predictor of how a carrier's plan will perform with QHP enrollees. Medicaid plans operate in a different regulatory environment and may be considerably more complex administratively, requiring social work skills among customer service staff, and involving greater enrollee education than commercial operations. At the same time, Medicaid plans don't have to interact with their members on claims in the same ways commercial plans do. Both Medicaid carriers and the carriers they will be competing with if they offer QHPs in the Exchange may be concerned that scores based on the Medicaid enrollment will not be comparable to scores achieved by commercial plans. There is some research indicating that plans serving both Medicaid and commercial enrollees might score about as well, on average, on some measures with each type of enrollee as plans that serve just one or the other type of enrollee. There is also some research indicating the Medicaid enrollees tend to rate their plans *differently*,

on average, than how commercial enrollees rate their plans^{2,3,4,5}. Consistent differences might be adjusted for, or might be made less important, if both the Medicaid plans and commercial plans were scored according to how they ranked relative to all plans for the same types of enrollees (commercial or Medicaid).

Advantages of Reporting Medicaid CAHPS data for a Commercial Product Type

- Carriers currently serving Medicaid enrollees and not able to collect CAHPS data on commercial enrollees would have the opportunity to have quality data reported about them.
- If the Exchange were to use CAHPS data on the singular topic of assessment of health plan, the data would be more directly comparable.

Disadvantages of Reporting Medicaid CAHPS data for a Commercial Product Type

- The Exchange would publicly report data on different populations (and would require some type of disclaimer acknowledging this).
- If the Exchange were to use CAHPS data in the composite manner developed by NCQA, the composite scores for the commercial CAHPS survey and the Medicaid CAHPS survey use different components. Data would be less comparable between commercial and Medicaid enrollees using this composite.

Option Three: Reporting Using NCQA's Accreditation Report Card

Current Data Availability

Among private commercial plans, four plans (Health Partners, Medica, PreferredOne, and Blue Cross Blue Shield) that account for about 88 and 96 percent market share respectively of Minnesota's individual and small group markets are currently accredited by NCQA. Sanford Health Plan, a nonprofit plan based in South Dakota but offering commercial insurance in Minnesota, also has NCQA accreditation. Figure 2 shows how accreditation ratings are presented on NCQA's own website.

Accreditation Ratings

NCQA Accreditation ratings summarize overall plan performance on a number of standards and measures. Plans with a higher NCQA Accreditation status can be generally expected to provide better care and service than plans with lower accreditation statuses. Plans with Health Plan Accreditation (HMO, POS or PPO) can receive a maximum of 4 stars in each category because HEDIS/CAHPS results are scored for these programs. View more information [about Accreditation ratings](#).

Accreditation Rating Criteria

Note: NCQA retired the Quality Plus Distinction listing for surveys effective July 1, 2010. NCQA Health Plan Accreditation incorporated the standards previously covered by the NCQA Quality Plus Distinction program starting with the 2008 Standards and Guidelines. Physician and Hospital Quality is now a certification program, click [here](#) to view statuses.

[Why is my plan not listed?](#)

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Plan Name ?	Plan Type ?	Accredited Product ?	Accreditation Type ?	Access and Service ?	Qualified Providers ?	Staying Healthy ?	Getting Better ?	Living with Illness ?	Overall Accreditation Status ?
BCBSM, Inc. (dba Blue Cross Blue Shield of Minnesota)	Commercial	PPO	Health Plan Accreditation	★★★★☆	★★★★★	★★★★☆	★★★★☆	★★★★☆	Commendable
HealthPartners, Inc.	Commercial	HMO/POS/PPO Combined	Health Plan Accreditation	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	Excellent
Medica	Commercial	HMO/POS/PPO Combined	Health Plan Accreditation	★★★★☆	★★★★☆	★★★★☆	★★★★☆	★★★★☆	Commendable
PreferredOne Community Health Plan	Commercial	POS	Health Plan Accreditation	★★★★☆	★★★★★	★★★★☆	★★★★☆	★★★★★	Commendable

Figure 2—How NCQA presents accreditation ratings

What is Being Measured

As shown in Figure 2, in NCQA’s report card system, plans are assigned an overall accreditation rating, which can be, from best to worst, Excellent, Commendable, Accredited, Provisional (a time-limited status), or Denied. In addition, there are five categories of performance by which to compare plans using a star ratings system (0 stars = worst; 4 stars = best):

- Access and Service
- Qualified Providers
- Staying Healthy
- Getting Better
- Living with Illness

Star ratings are calculated using a combination of Healthcare Effectiveness Data and Information Set (HEDIS) measures (focused on clinical care process and outcomes), CAHPS survey results, and accreditation standards (emphasizing health plan organizational structure and process). The plan’s score is divided by the best possible score, and the resulting proportion is used to determine the number of stars the plan receives⁶. The Accreditation Report Card is well-suited to consumers who are not quantitatively oriented; rather than displaying number scores, the overall rating is an adjective and performance is described using pictures of stars.

In the NCQA Report Card, the consumer cannot drill down to see the measures contributing to the star ratings in a category, such as measures of having enough primary care doctors. But the Report Card reflects plan performance on a wide range of aspects of quality to which consumers can easily relate. The Massachusetts Health Connector uses the NCQA Report Card ratings (the overall accreditation rating and the star scores for the five categories) for its quality information.

The Minnesota Exchange could present the overall accreditation rating (Excellent, Commendable, etc.) either in a word or converted to a symbol as a summary quality measure. The summary might potentially link to another page to take interested consumers to the Report Card ratings in the five categories.

Advantages of Option Three:

- This approach would be relatively simple to implement for the carriers that are already accredited by NCQA.

Disadvantages of Option Three:

- It is not possible to drill down to see the measures contributing to the star ratings in a category used in the NCQA Report Card.
- Reporting of the accreditation rating would leave a gap for plans offered by unaccredited carriers. It requires approximately 18 months to obtain accreditation through NCQA and unaccredited carriers cannot meet this timeline prior to the launch of the Exchange. Therefore, it is a possibility that use of this option will result in some carriers not having quality data associated with their products.

Option Four: Reporting on NCQA's Health Insurance Plan Rankings

Every September, NCQA releases rankings of health plans based on three types of quality information: HEDIS clinical measures, CAHPS consumer experience measures, and evaluation of the plan based on NCQA's accreditation standards⁷. As shown in Figure 1, above, the ranking information is reported in detail on NCQA's website on a plan-per-page basis. The rankings information is also published by *Consumer Reports* annually in October, where plan scores can be seen side-by-side in summary form or in detail for up to five plans, as shown in Figure 3.

Current Data Availability

Similar to the measures discussed in Options Two and Three, among private commercial plans, four carriers (Health Partners, Medica, Blue Cross Blue Shield and Preferred One) that together account for about for about 88 percent and 96 percent market share respectively of Minnesota’s individual and small group markets, are currently included in NCQA’s rankings system. Sanford Health Plan is also included in this system.

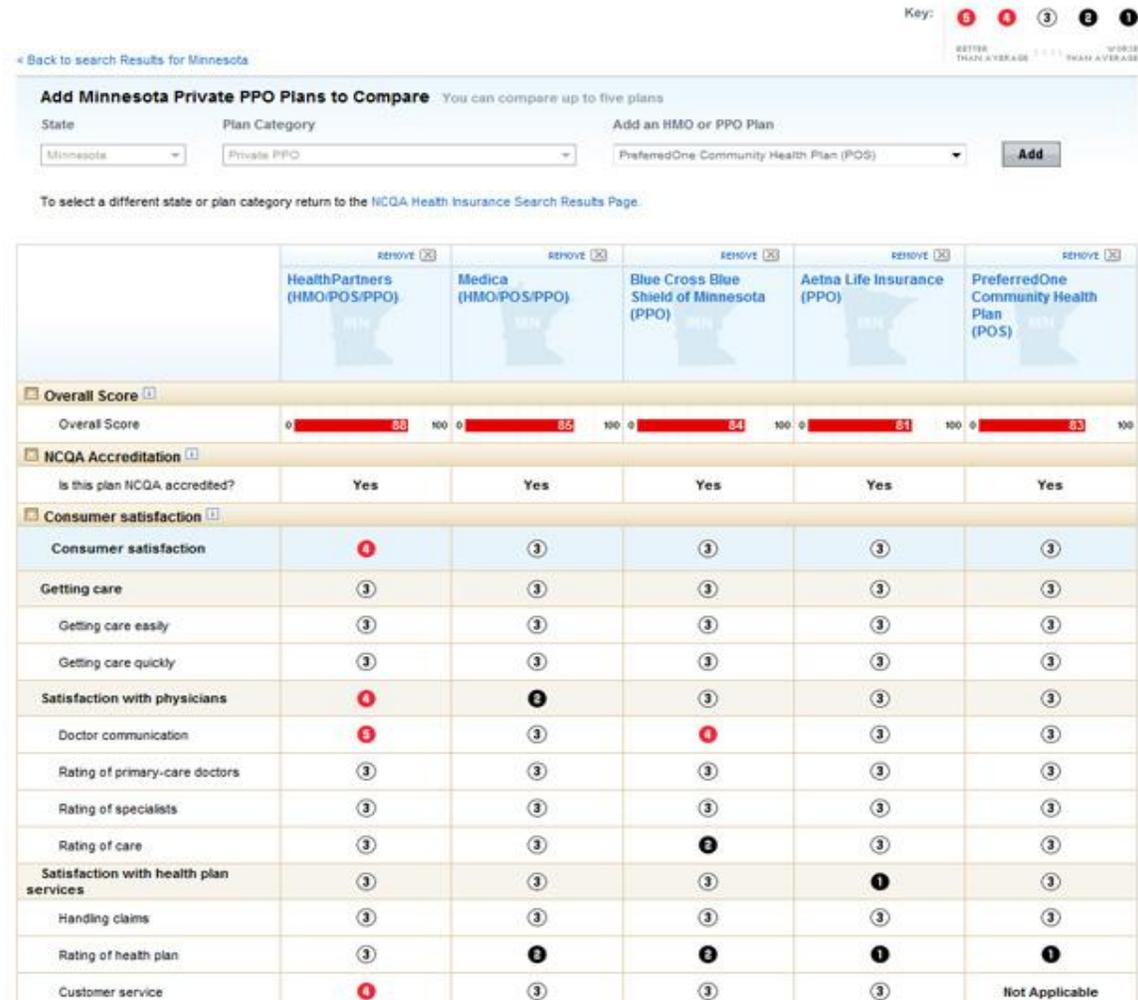


Figure 3: A portion of NCQA’s plan rankings in a side-by-side comparison on the Consumer Reports website

What Is Being Measured

The report of plan rankings on the NCQA website shows for each plan or carrier—

- An overall score (on a 0 to 100 scale) based on a standardization and weighting of all the CAHPS and HEDIS scores shown in the ratings presentation and on the accreditation status of the carrier/plan;
- A ranking of the plan/carrier relative to all other plans/carriers in the same business line (commercial, Medicaid, or Medicare) in the U.S. included in the ranking system;
- An indication of whether the plan is accredited by NCQA (yes or no);

- Scores (on a 1 to 5 basis in circles that are colored to correspond to numerical score) in three broad major categories of measurement (“Consumer Satisfaction,” “Prevention,” and “Treatment”);
- Similarly displayed 1 to 5 scores on measurement subcategories like “Satisfaction with Physicians” or “Diabetes” treatment;
- Similarly displayed 1 to 5 scores on individual CAHPS questions or composites and HEDIS measures like “Glucose control” and “Breast cancer screening.”

Although there are overlaps in quality information, there are several distinctions between the Plan Rankings and the Accreditation Report Card. Health plans can agree to publicly report HEDIS/CAHPS data in the NCQA rankings system without going through NCQA accreditation; however, the scores of plans not accredited by NCQA will be lowered by 15 points because 15 of the 100 points for the overall score in the ranking system depend on NCQA accreditation status⁷.

Advantages of Option Four

- There is significant consistency in currently available data across carriers. All Minnesota carriers that publicly report in the Health Insurance Plan Rankings are accredited; thus these same plans are displayed in NCQA’s Accreditation Report Card.
- This Option Four approach would probably be fairly easy to implement for the carriers that are already accredited by NCQA and that already report most or all the HEDIS and CAHPS measures used in the Rankings provided it is permissible for the Exchange to use these data.
- As compared to Option Three, the overall score in NCQA’s ranking system is displayed on a 0-100 scale, thus potentially allowing for more variation and ability to distinguish among plans than is possible with the Accreditation Report Card’s overall rating, which has just a few categories (Excellent, Commendable, etc.).
- As compared to Option Three, the plan rankings display is more transparent about the measures that contribute to the overall score and allows more opportunity for consumers to drill down for measures included in each category than the Accreditation Report Card allows.

Disadvantages of Option Four

- It is not possible for carriers not currently reporting data to do so prior to the launch of the Exchange. Therefore, it is a possibility that use of this option will result in some carriers not having quality data associated with their products.
- While it is possible to drill down into categories, this drill-down largely focuses on “Prevention” and “Treatment.” These are dimensions of clinical quality and many consumers attribute clinical quality more to their health care providers (or individual behavior) than to their health plans.
- Measures of access, provider networks, and health plan services (including customer service and claims handling), which are highlighted in the Access and Service and Qualified Providers dimensions of the NCQA Accreditation Report Card, may be more salient to consumers—as might CAHPS/Consumer Satisfaction measures.
- The Exchange might be able to obtain the ranking information directly from NCQA at a modest cost, but NCQA has not yet confirmed whether contractual constraints might prevent NCQA from authorizing the Exchange’s use of such data.

Many of the considerations with regard to basing the Minnesota Exchange's quality reporting on NCQA's ranking system are similar to considerations discussed under Option Three, above, with regard to basing Minnesota's quality reporting on the Accreditation Report Card system.

Option Five—Use a Combination of Above Options

This option would provide a wider range of information than any individual option, but might create larger burdens of implementation and might, depending on how presented, lead to information overload for consumers. An example of such a combination may be to use the "Rating of Health Plan" score for a summary quality measure for each QHP with a link to data on a subset of HEDIS measures for those carriers with available HEDIS data.

Conclusion

Among the many available options for a quality reporting system for 2013 open enrollment, the following would be a valuable and feasible option:

- On the initial plan comparison summary screen, the Exchange presents for each available plan an overall quality measure.
- This overall quality measure is the "Rating of Health Plan" score from the CAHPS survey and has the heading "How Members Rated the Plan" or similar.
- As soon as possible, the Exchange lets all carriers that are likely to want to participate in the Exchange know that CAHPS scores will be used in quality reporting.
- If some of the plans cannot produce CAHPS scores for commercial enrollees but can produce such scores for Medicaid enrollees, the scores for the Medicaid-only plans are shown along with the scores for the commercial plans with a reasonably prominent note about data being reported on two different populations.

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