



The Measurement and Reporting Work Group has provided input about core dimensions of quality that should be measured in a Quality Rating System. Work Group members have indicated that network adequacy and health disparities are two key priority areas that should be measured as part of the quality rating system. Cost must also be incorporated into the quality rating system. The purpose of this memo is to identify potential gaps in measuring high-priority dimensions of health plan quality and possible strategies for addressing these gaps.

Gaps can be defined to include quality dimensions for which a scan of the measurement literature does not identify any measures, or a sufficiently comprehensive range of measures, that help achieve measurement of key priority topics. Gaps may also surface if the cost and effort required for measurement is unreasonably burdensome.

Disparities

The Measurement and Reporting Work Group has set as a guiding principle that it will actively seek out and consider opportunities to reduce health disparities. Part of the Measurement and Reporting Work Group's charge is to provide advice on how to measure the presence of health disparities and to assess progress in reducing those disparities over time.

There is strong evidence of *health* disparities. For example, a report by the Minnesota Department of Health looking at data for 2003 through 2007 found that the rates of HIV new infections, chlamydia incidence, and infant mortality among African Americans were 17.2 times, 14.4 times, and 2.0 times, respectively, as high as the rates among Whites¹. There is also much evidence of disparities in health *care*. A recent Kaiser Family Foundation report summarizes research showing that low-income individuals, people of color, and people with limited English proficiency experience more barriers to care, receive poorer quality care, are less likely to seek care, and/or may have different patient experiences and levels of satisfaction.²

Health plan quality *measurement* can address disparities in various ways. Measurement can guide health plan quality improvement efforts, employer purchasing decisions, and consumer choices. The specific charge of the Work Group is to use measurement to assist consumers to choose the plans that best meet their needs. This will also promote competition among carriers on quality and customer services. Measurement for reporting to consumers can address disparities through any of several approaches:

1. Measurement of the performance of a plan overall without specifically assessing performance by population groups can create incentives for overall improvement in plan performance and is likely to improve performance for all groups, although the groups likely to benefit most will be those for whom incremental improvement will have the largest impact on the plan's overall score.
2. Measurement of the performance of a plan focused on health conditions most prevalent among specific demographic groups can target the impact. Thus, measuring performance on prevention of infant mortality may be particularly relevant to African Americans while measuring

¹ Health Disparities by Racial/Ethnic Populations in Minnesota. MDH. December 2009.

² Focus on Health Care Disparities. Kaiser Family Foundation. December 2012.

performance on suicide prevention may be particularly beneficial to American Indians, as these two health issues are experienced at highly disparate rates for these populations.³

3. Focusing measurement not only on the condition but also on the most relevant *point* in the health care service delivery process for disparate populations is also important. For example, breast cancer screening may be a good indicator of breast cancer outcomes for the majority of the population, but women of color are less likely to receive appropriate follow-up after receiving an abnormal screening result. Measurement of follow-up is, therefore, more important for this population. Similarly, breakdowns in communication and trust during the delivery of health care services due to cultural insensitivity are more relevant for populations of color.

Approaches 2 and 3 are limited by the fact that there are relatively few measures that have been singled out as disparity-sensitive and are endorsed for measurement at the health plan level as opposed to the physician, clinic, or hospital level. It may be possible to adapt some of the measures endorsed for other levels to suit the health plan level. More difficult will be developing more measures that address conditions that have especially high incidence among minority populations (e.g. HIV) or address points in care where slippage is especially problematic for certain populations (e.g. follow-up after an abnormal breast cancer screening result). To target conditions and care processes most applicable to disparities, the Exchange should continue to follow the activities of NQF (including its listings of disparities-sensitive measures), the U.S. Department of Health and Human Services (specifically ARHQ's Excellence Centers to Eliminate Ethnic/Racial Disparities and the CDC's Racial and Ethnic Approaches to Community Health), and recognized measure developers such as NCQA, CMS, and URAC. And the Exchange should encourage developers to produce disparities-sensitive measures and get them endorsed.

4. Measurement can also seek to evaluate the appropriateness and quality of the care processes and outcomes experienced by different population groups through stratification of quality measure results on a group-by-group basis. For example, are certain racial, ethnic, or socioeconomic groups more likely to get flu shots, cervical cancer screenings, or hemoglobin A1c tests? Are these groups more likely to report better patient-provider communication on CAHPS surveys?

This stratification can be done to identify differences/disparities among groups. If differences are found, consumer reporting can show each carrier's relative performance for different groups—a direct measure of disparities that some consumers might be interested in seeing to assess the extent to which a carrier is successfully reducing or eliminating disparities.

To target measures where there may be differences in appropriateness and quality of care, the Exchange should follow the same activities of NQF, HHS, NCQA, and the other organizations mentioned above with regard to the identification of disparities-sensitive measures. The Exchange should also collaborate with the MDH's current work in health disparities to focus on measures most relevant to the Minnesota community.

Data Collection Issues: Approaches 2 and 3 may require, and Approach 4 certainly requires, measurement to be applied to specific racial and ethnic groups. One challenge is identifying the groups to which each plan enrollee belongs. DHS already collects demographic information from applicants to the Minnesota Health Care Programs, but collection of race/ethnicity information is often not readily

³ Health Disparities by Racial/Ethnic Populations in Minnesota. MDH. December 2009.

implemented by commercial health plans⁴. Consumers may be reluctant to self-report such information to their health plan, and carriers may be concerned that the very act of collecting such information will be perceived negatively. Ways to minimize this problem are to be extremely transparent about why such information is needed (to monitor quality to ensure that all patients get the best care possible), to use standard U.S. Office of Management and Budget demographic categories, to collect no more categories than can be constructively used, and to make clear the legality of such data collection.

Although racial/ethnic information would need to be collected for each member for inclusion in analysis for HEDIS-type clinical measures, this is not needed for surveys of members. The CAHPS survey instruments directly collect for each respondent demographic information that can be used for analysis of health disparities.

Even if plans have the demographic information needed for clinical or survey measures, measurement of plan performance for individual demographic groups might be unreliable because of limited sample sizes; even where plans have enough members in a group, there will be the cost of collecting adequate sample sizes for each group. The Exchange will have to do significant research and testing to determine for which groups and for which measures there are likely to be enough available members and enough important differences in performance to justify the cost. A future memo will more systematically address strategies for addressing small sample sizes.

5. Another measurement approach is to look at the policies, programs, resources, and management processes a plan has to reduce disparities. RAND's Cultural Competence Implementation Measure is an example of such a measure and is included in the proposed quality rating system measure set. It is a survey filled out by the organization (such as a health plan) being evaluated, to assess the degree to which the organization is providing culturally competent care and addressing the needs of diverse populations⁵. For example, it asks whether the organization has "involved consumers and the community served in the development of a strategic plan that has clear goals that include providing culturally competent care." Another example of such a measure is NCQA's Multicultural Health Care Distinction Program, which has standards that require plans to "collect members' ethnicity/language data," "demonstrate use of competent translators," and "collect, report and analyze clinical quality and patient experience measures by race, ethnicity, and primary language."⁶ The eValue8 measure set also has components that address disparities—for example, a review of "health plan activities to use racial, cultural, and language information from its members to improve the care and service they receive."⁷

This is a feasible approach that might resonate with consumers. But it poses a challenge for the Exchange to select measures that are rigorous enough for public reporting. For example, the RAND-developed Cultural Competency survey has not yet been tested for use in consumer plan-choice-making and does not include procedures for auditing the accuracy of plans' reporting. The eValue8 measure is not transparently documented. In addition, determining that a health

⁴ Collection of Racial/Ethnic Health Data by Minnesota Departments of Health and Human Services. MDH & DHS. January 2011.

⁵http://www.qualityforum.org/News_And_Resources/Press_Releases/2012/NQF_Endorses_Healthcare_Disparities_and_Cultural_Competency_Measures.aspx

⁶ <http://www.ncqa.org/Portals/0/Public%20Policy/NCQA%20MHC%20fact%20sheet.pdf>.

⁷ Puget Sound Community Checkup: An Ongoing Report to the Community on Health Care Performance Across the Region. Puget Sound Health Alliance. August 2012.

plan has culturally sensitive management processes is not the same as a direct measure of the results in terms of quality of care for disparate populations.

Whatever measurement approaches are used, there will still be challenges in reporting results meaningfully to consumers. To date, information on disparities is often available at the state or national level, with the primary research focus being broad public health interventions. Presenting health disparity information to consumers to help them choose plans would be different. Are consumers satisfied to know that a plan performs well on a measure on average for its entire membership without knowing how the plan does for people like themselves?

Network Adequacy

The Exchange has established network adequacy standards for the first year of Exchange certification and operation. These standards are in place so that each network has a sufficient number and variation in provider types within a given geographic area to ensure consumers have access to care. Quality measurement of network adequacy, however, is a different concept. Quality measurement related to network adequacy may potentially relate to the breadth and depth of a network; the quality of clinics and hospitals in that network; or the ease with which enrollees may obtain needed services from network providers, including both primary care and specialists.

There are limited existing measures related to network adequacy. Seven measures have been included in the proposed measure set related to network adequacy:

- The NQF-endorsed CAHPS health plan survey instrument includes questions that address “Getting Needed Care” and “Getting Care Quickly” in the member’s plan. This survey also collects members’ ratings of primary care providers and specialists in the plan.
- Other non-NQF endorsed NCQA measures of access include a) percentage of children who have had a primary care visit during the measurement year and b) percentage of adults who have had a preventive or ambulatory care visit in the year or two prior to the measurement year. These clinical measures estimate the network adequacy concept, but cannot distinguish between the patient’s inability to receive care versus the patient’s choice not to receive care. A carrier should be responsible for ensuring that members receive appropriate care; however, measures such as the ones described above may relate both to network adequacy as well as to plan programs and services that are effective in educating consumers about the value of preventive care.
- URAC is proposing to include two (non-NQF-endorsed) measures that more directly relate to provider network adequacy by giving counts of the number of specialists and primary care providers that are accepting new patients, stratified by provider type and zip code.
- eValue8’s Provider Measurement module emphasizes measuring and rewarding provider performance to help physicians deliver better care. These measures investigate how effectively a plan uses incentives to promote high performing providers. This module addresses the “quality” of the provider network; so that consumers can be assured that the plan not only makes providers accessible, but also strives to promote quality of these providers.

In addition to these measures, there are other measures that may also be considered related to network adequacy, such as NCQA's measure of "well-child visits in the third, fourth, fifth, and sixth years of life" from the HEDIS measure set—giving some sense of the feasibility of getting access to doctors. This measure is included in the proposed measure set, but as part of a different category.

The Exchange could consider combining information on provider networks and data collected by the Minnesota Department of Health about clinic and hospital quality of care to calculate statistics on network quality. Such measurement could include the number of high quality clinics that participate in a provider network and/or the percentage of a network's clinics that are high quality. It should be noted that quality data about clinics and hospitals are generally related to specific conditions and processes of care and are not currently aggregated into an overall quality measurement for these providers. This would require a substantial effort.

Plan Programs

There are many programs that plans can offer to contribute to member health. The eValue8 measurement system developed by the National Business Coalition on Health focuses on many such programs. Examples are a plan's program to provide a health assessment tool to inform members about how to stay healthy, programs to remind members about routine cancer screenings or immunizations that are overdue, programs that provide members help with smoking cessation or weight management, and programs to provide a nurse advisor for health inquiries 24 hours a day. Seven such eValue8 measures are included in the proposed measure set. NCQA and URAC also look at some types of programs in their accreditation reviews.

The sense in which there is a measure gap in programs of this kind is that the eValue8 measures were initially developed to inform employer purchasers rather than consumers, meaning that some adaptation may be required to translate these measures into meaningful consumer information. For example, more plain language explanations of the measures could be developed for a consumer audience. In addition, rather than a system of "earned points" for a measure, measures could be translated into a score based off of a) the proportion of points earned out of the total points possible; or b) the significant differences in performances between plans (significantly better, average, or worse). Also, the eValue8 measures are not as transparent as HEDIS and CAHPS measures and many are qualitative in nature. As some measures are based on evaluator judgments, they may raise concerns about how consistently carriers are being scored on the measures. The same may be true of some of the program assessments used in accreditation. Despite these challenges, Consumers' Checkbook/CSS believes it makes sense for at least some components of the eValue8 measure set to be included in the proposed Quality Rating System. The range of health care quality topics it covers through review of the plans' programs and systems would enhance the value of the Quality Rating System. Nationally, large employer groups value the information provided to them through the eValue8 measures for choosing employee health plans. The Exchange can engage the National Business Coalition on Health on how best to use the eValue8 measures in a consumer-facing format.

Costs

The Quality Rating System is required to include measurement of cost in some way. Federal regulations will be issued in the future about the quality rating system and they may include more specific direction on how cost is to be incorporated. The Minnesota Health Insurance Exchange is considering how most appropriately and effectively to incorporate a cost dimension into the Quality Rating System. Measurement of cost may potentially relate to factors that contribute to overall health care system costs and/or to costs consumers may incur.

One approach to measuring cost would be to assess effective resource utilization. Two measures are proposed for inclusion in the quality rating system that measure relative resource use for two conditions: the NQF-endorsed measures of relative resource use for people with diabetes and for people with cardiovascular conditions. Other examples of overuse measures include *cardiac stress imaging not meeting appropriate use criteria: preoperative evaluation in low risk surgery patients* and *MRI of the lumbar spine with a diagnosis of low back pain for which the patient did not have prior claims-based evidence of antecedent conservative therapy*. For such measures to work in reports to consumers, it may be necessary to explain prominently that poor scores might indicate that a plan's members may be paying more than necessary out-of-pocket through deductibles or coinsurance.

Another approach to measuring cost would be to incorporate information produced by the Exchange's total out-of-pocket cost calculator and premiums into the quality rating system. A significant level of analysis and measure development work would need to be done to explore this concept.

Outcomes

There are various HEDIS measures that look at intermediate outcomes for which there is evidence of a connection with long-term outcomes. Measures of whether blood pressure or hemoglobin A1c meet certain thresholds are examples.

There are far fewer measures currently endorsed for the health plan level that look beyond such intermediate outcomes. But there are measures in wide use by CMS and others for evaluating hospitals by looking at clinical outcomes beyond intermediate outcomes. These include measures of complication and death rates in hospitals and 30-day death rates in cases of heart attack, stroke, pneumonia, and other conditions or procedures. The Exchange might explore adapting such measures for use at the plan level where there are adequate sample sizes, or at the carrier level.

There are very few measures of patient-reported outcomes for use at any level. Yet consumers are very interested in such outcomes—will I be able to get dressed by myself, walk normally, play basketball, and be pain-free? And there is increasing collection of such outcome information (for example, in Britain's National Health Service and in systems that have advanced electronic health records). The Exchange will not have many, if any, measures available to address such questions in the near term but can add its voice to the call for such measures.

Discussion Questions:

- Are there gaps in available measures in other high priority topics to be included in the quality rating system?
- What strategies may be the best approach for addressing these gaps?
- Are there other strategies for addressing gaps beyond those noted here?