

Dimensions of Insurer Quality Measurement

Issue Paper Prepared for the Health Insurance Exchange Measurement and Reporting Work Group

By Health Insurance Exchange Staff

April 13, 2012

This background paper provides information on potential data sources and dimensions of insurer quality to assist the Work Group as it considers options for how to devise a quality rating system for insurers and Qualified Health Plans (QHPs). This background paper is intended to provide a starting point for discussion.

SOURCES OF INSURER QUALITY DATA

There are several existing sources of quality data for health insurers, including those listed below.

- The National Committee for Quality Assurance (NCQA) is a national not-for-profit organization which offers a variety of accreditation and certification programs, including health plan accreditation. The NCQA health plan accreditation process evaluates core structural and process systems, as well as the actual results that the plan achieves on key dimensions of care, service, consumer satisfaction and efficiency.¹ The performance results from the accreditation process include star ratings in access and services, qualified providers, staying healthy, getting better, and living with illness. Additionally, NCQA produces and maintains the Healthcare Effectiveness Data Information Set (HEDIS) measures. HEDIS measures include those related to effectiveness of care, access and availability of care, utilization and relative resource use, and health plan descriptive information. HEDIS measures are used in the context of NCQA's accreditation process and are also incorporated in Minnesota's and other states' health insurer quality measurement initiatives.
- The Minnesota Department of Health (MDH) conducts the Managed Care Quality Assurance Examination of Minnesota health maintenance organizations and county based purchasers. This examination includes evaluation of quality program administration, internal complaints and appeals, provider availability and accessibility, and compliance with Minnesota's utilization review law. MDH also audits additional requirements applicable to managed care organizations serving Medical Assistance and MinnesotaCare enrollees as part of its quality exams. The Quality Assurance Examination is required for health plans to maintain licensure and accreditation.
- The Minnesota Department of Human Services (DHS) also conducts annual quality evaluations to assess "strengths and weaknesses" in the Quality, Timeliness and Access of care and services provided to Minnesota Health Care Program (MHCP) managed care enrollees. DHS' evaluation uses HEDIS measures and a consumer satisfaction survey described elsewhere in this paper. DHS also calculates a set of Ambulatory Care Sensitive Condition measures developed by the Agency for Health Care Research and Quality (AHRQ), which examine conditions "for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease" (AHRQ 2004). DHS uses these additional utilization measures to assess the appropriateness of care provided in the ambulatory care setting. DHS also annually calculates financial disincentives related to specific compliance issues, lead screening, emergency department utilization, hospital admissions and readmissions.
- The National Business Coalition on Health (NBCH) sponsors the eValue8 survey. Participation in eValue8 requires data submission on seven measurement modules including plan profile, consumer engagement, provider measurement, pharmaceutical management, prevention and health promotion, chronic disease

¹ NCQA. "Health Plan Accreditation." Found online at <http://www.ncqa.org/tabid/689/Default.aspx>.

management, and behavioral health. Participation is voluntary and in 2010 one Minnesota insurer participated.

CLINICAL CARE

This category consists of measures that reflect whether patients received recommended treatment or preventative screenings. The NCQA HEDIS Effectiveness of Care measures assess whether the patient received the appropriate treatment or preventative measure for a certain condition or illness. Different subsets of these measures are required as a part of NCQA accreditation, the MDH Managed Care Plan licensure and accreditation process, and the DHS MHCP evaluation.

COMPLIANCE

Compliance is typically thought of as meeting the expectations of those who grant money, pay for services and regulate the health care industry.² For purposes of this paper, this category includes quality management programs, as well as credentialing and systems for investigating and resolving complaints. These initiatives and processes are typically required by statute or by purchasers.

CONSUMER ENGAGEMENT

This category includes information related to how the health plan engages consumers in their care. Research has shown that engaged consumers have the potential to improve health care quality and their own health outcomes as they take a more active role in their care. The types of consumer engagement described here address an insurer's tools to help patients improve their health and navigate their care system, including assessments regarding wellness and prevention programs, and self-management tools.

RESOURCE MANAGEMENT

This category includes information about utilization management and relative resource use. Utilization management is the "evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan."³ This process manages costs as it influences the use of unnecessary services and procedures. Relative resource use measures represent a health plan's spending for members with a specific condition compared to a risk-adjusted average.

HEALTH PLAN CHARACTERISTICS

This category includes some basic information about the health plan. These components are more descriptive, including data like enrollee demographics and accreditation status. This type of data allows consumers to have more detailed general information about the health plan and its enrollees. This also includes topics such as the health information technology capabilities, how the plan works with employers to promote safe and effective care, and a plan's ability to provide culturally sensitive services.

² Health Care Compliance Association. "Compliance." Found online at <http://www.hcca-info.org>.

³ Utilization Review Accreditation Commission. "Utilization Management." Available online at <https://www.urac.org/resources/caremanagement.aspx>.

NETWORK ADEQUACY AND PROVIDER PERFORMANCE

This category includes measures that relate to an enrollee's access to primary, specialty and other types of care. This could include provider network criteria related to the number of providers available, provider to patient ratios, and geographic proximity of providers to health plan enrollees. This category also includes measures of the extent to which insurers measure provider performance and incent use of high quality providers.

ENROLLEE SATISFACTION

This category includes enrollees' satisfaction with the care they received. One method for measuring this component is the AHRQ Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tool. This survey asks consumers and patients to report on and evaluate their experiences with health care. The CAHPS survey covers topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services.⁴ Currently, components of the CAHPS survey are required for NCQA accreditation and used by DHS to assess how well a managed care organization and its providers are meeting the needs and expectations of enrollees.

FUTURE DATA

In the near future, additional data will be available through certain provisions of the Affordable Care Act (ACA). One such provision is the Transparency in Coverage Disclosures⁵, which requires non-grandfathered health plans to submit information which inform consumers about key features of their benefit plan. Some examples of the type of information that will be submitted include claims payment policies and practices, periodic financial disclosures, and data on enrollment and disenrollment. This requirement will impact plans inside and outside of the Exchange with the law requiring Exchanges and the U.S. Department of Health and Human Services to publicly report the information.

Another provision of the ACA creates a Medical Loss Ratio⁶ (MLR) requirement. Health plans and insurers will be required to report the percentage of premium dollars spent on health care, quality improvement and other activities. Insurers must spend at least 80 percent of premiums on medical care and quality improvement activities. Quality improvement initiatives that can be counted toward the 80 percent minimum threshold include activities to improve health outcomes, activities to prevent hospital readmissions, wellness and health promotion activities, improve patient safety and reduce medical errors, and health information technology supporting these efforts.

ISSUES FOR DISCUSSION

As the work group explores this topic, the following key issue should be considered:

- What dimensions of quality should be incorporated into a quality rating system for insurers/health plans?

⁴ Agency for Healthcare Research and Quality. "About CAHPS." Found online at: <http://www.cahps.ahrq.gov/About-CAHPS>.

⁵ Section 2715A Public Health Service Act, Section 1311(e) ACA.

⁶ Section 2718 Public Health Service Act, Section 1001 ACA.

The following tables identify currently available measures mentioned above. The tables represent a broad comparison of this data and should not be considered an all inclusive list. The numbers noted in each section are a count of all of the individual components for that data source; however, not all of those measures may be applicable for a particular plan.

CLINICAL CARE	
Healthcare Effectiveness Data and Information Set (HEDIS) Measures	
<u>Effectiveness of Care</u> (42), examples as follows:	
<ul style="list-style-type: none"> • Appropriate breast cancer screening in women • Appropriate medication for people with asthma 	<ul style="list-style-type: none"> • Appropriate treatment for adults with bronchitis • Glaucoma screening in older adults

COMPLIANCE	
Minnesota Department of Health (MDH) Managed Care Quality Assurance Examination	
<u>Quality Program Administration</u> (5), examples as follows:	
<ul style="list-style-type: none"> • Quality assurance plan and work plan 	<ul style="list-style-type: none"> • Quality studies and activities
<u>Complaints and Grievance Systems</u> (11), examples as follows:	
<ul style="list-style-type: none"> • Complaint resolution 	<ul style="list-style-type: none"> • Appeal of the complaint decision
National Committee for Quality Assurance (NCQA) Accreditation	
<u>Quality Management and Improvement</u> (12), examples as follows:	
<ul style="list-style-type: none"> • Program structure and operations 	<ul style="list-style-type: none"> • Clinical practice guidelines
<u>Credentialing and Recredentialing</u> (12), examples as follows:	
<ul style="list-style-type: none"> • Credentialing policies 	<ul style="list-style-type: none"> • Ongoing monitoring

CONSUMER ENGAGEMENT	
eValue8 Survey	
<u>Behavioral Health</u> examples:	
<ul style="list-style-type: none"> • Whether and how plans help providers screen members for behavioral health issues • How the plan monitors medication compliance 	
<u>Chronic Disease Management and Member Identification</u> examples:	
<ul style="list-style-type: none"> • How effectively a plan helps coordinate care for patients with multiple conditions • Whether the plan supports patients with a wide variety of tools and interventions that are activated when needed to avoid adverse events and help members understanding their conditions 	
<u>Consumer Engagement</u> examples:	
<ul style="list-style-type: none"> • Shared decision making • Self-management tools 	<ul style="list-style-type: none"> • Encouraging the use of quality data • Performance on CAHPS survey
<u>Pharmaceutical Management</u> examples:	

CONSUMER ENGAGEMENT

- How the plan promotes adherence to prescription regimens
- Identifying and closing gaps in care by monitoring and influencing patient compliance and adherence

Prevention and Health Promotion examples:

- Strategies for getting members to complete health risk assessments
- Plan programs for using health risk assessment information to guide members to needed care

NCQA Accreditation

Member Connections (9), examples as follows:

- Self-Management tools
- Encouraging wellness and prevention

RESOURCE MANAGEMENT

Ambulatory Care Sensitive Condition Measures

Use of Services (16), examples as follows:

- Uncontrolled diabetes admission rates
- Dehydration admission rates
- Congestive heart failure admission rates
- Diabetes lower extremity amputation rate

HEDIS Measures

Utilization and Relative Resource Use (16), examples as follows:

- Frequency of ongoing prenatal care
- Mental health utilization
- Adolescent well-care visits
- All-cause readmissions

MDH Managed Care Quality Assurance Examination

Utilization Review (10), examples as follows:

- Procedures for review determination
- Confidentiality
- Staff and program qualifications

NCQA Accreditation

Utilization Management (15), examples as follows:

- Clinical criteria for utilization management decision
- Document and reasons for denying services

HEALTH PLAN CHARACTERISTICS

eValue8 Survey

Health Plan Profile examples:

- Whether and at what level the plan has been accredited
- Plan's information technology structure and how effectively it is used to coordinate care and make it safer

HEDIS Measures

Health Plan Description Information (7), examples as follows:

- Race/Ethnicity diversity of membership
- Enrollment by product line

NETWORK ADEQUACY AND PROVIDER PERFORMANCE

HEDIS Measures

Access/Availability of Care (7), examples as follows:

- Adults with ambulatory or preventative care visits
- Children with a primary care provider visit
- Adolescence or adults with alcohol or drug dependence who received certain types of treatment

MDH Managed Care Quality Assurance Examination

Access and Availability (8), examples as follows:

- Geographic location of providers
- Coordination of care activities

eValue8 Survey

Provider Performance examples:

- Whether and how effectively a plan uses incentives to promote high performing providers
- How plans use clinical performance, relative efficiency and other data to differentiate among doctors and hospitals

PATIENT SATISFACTION

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

There are health plan CAHPS surveys in the following areas:

- Commercial population (adults and children)
- Medicaid population (adults and children)

Additional item sets in the following areas:

- Children with chronic conditions
- Adults with mobility impairments

The survey tool includes questions in the following areas:

- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Health Plan Information and Customer Service
- Overall Rating