



Options for a Medicaid Quality Rating System  
May 10, 2013

The Measurement and Reporting Work Group (MRWG) has reviewed various methodological issues in the development of a Quality Rating System (QRS) for MNsure. Until this memo, these issues have been discussed in the context of commercial products to be offered on MNsure. Another MNsure function will be to provide certain Medicaid-eligible individuals with the ability to choose a managed care organization as part of their Medicaid enrollment. It is anticipated that, due to changes in income levels, many consumers will move between eligibility for Medicaid and affordability assistance to purchase commercial products over time. Thus, it is desirable that these consumers have a similar health plan shopping experience across Medicaid and the commercial market to the extent possible.

DHS has considered the proposed QRS framework and made a series of working decisions regarding how to tailor the proposed QRS to a system that will be appropriate for Medicaid. This memo will comment on those working decisions, in order to foster MRWG feedback for DHS's consideration.

*Working Decision One: Use the Adult Medicaid CAHPS survey measures as the QRS measures with supplemental information on a selected set of HEDIS measures.*

The Minnesota Managed Care Public Programs' Adult Medicaid CAHPS survey is conducted annually by an NCQA-certified CAHPS vendor, under contract with the Minnesota Department of Human Services (DHS). The results of this survey are publicly reported both on DHS's website and in managed care program enrollment materials. DHS has identified these results as being very useful to managed care clients. The Adult Medicaid CAHPS survey includes about 12 percent of the currently proposed commercial QRS measures, spanning several aspects of quality: *What Members Say about their Health Care, Access to Quality Health Care, Quality of Customer Service and Claims Processing, and Overall Health Plan Quality*. These measures are intuitive to consumers (e.g. how often did other people in this plan have a good experience?) and applicable to a broad audience (as opposed to, for example, measures under *Mother and Baby Staying Healthy*, which focus on a more specific population). The supplemental HEDIS measures that DHS is considering would be selected with an eye to the specific needs of the public program participants, such as some women's health measures and Well-Child visits, for example.

Checkbook/CSS considers use of the CAHPS survey results and select HEDIS measures as a reasonable approach to demonstrating health plan quality. It gives the consumer a broad picture of quality from other consumers' perspectives. However, there are several other measures proposed in the QRS that might also be useful to consumers in making plan choices and to health plans in driving quality improvement. Medicaid plans are contractually obligated to meet certain quality thresholds on particular measures, which are monitored by DHS. These current withhold measures address aspects of quality such as emergency room use and hospital admissions and readmissions. But many HEDIS clinical measures proposed in the QRS are also collected by DHS. Because DHS conducts internal quality controls on these measures, there may be little variation among managed care organizations on these types of measures, rendering them less useful in drawing distinctions among plans. However, reviewing MN Medicaid plans using 2012 NCQA Plan Rankings shows preventive care scores ranging from 3 (average) to 5 (best score possible)<sup>1</sup>. Thus, depending on the final methodology for displaying scores, there could be some distinctions made among Medicaid plans on these HEDIS measures. Even if no obvious distinctions could be made among plans on the measures, the measures at the very least would be reassuring to consumers that every plan performs equally well. This may be especially true for measures related to care of chronic conditions such as diabetes and heart disease, as the Medicaid-population bears a disproportionate burden of these conditions compared to the commercially-insured population<sup>2</sup>.

Another source of health plan quality measures not currently proposed in the QRS, but applicable to the Medicaid population, is the set of measures from the Child Medicaid CAHPS survey. This survey is not federally required, but can be used in place of the Adult Medicaid CAHPS survey for NCQA plan accreditation. If the Child Medicaid CAHPS survey is conducted instead of the Adult Medicaid CAHPS survey, then NCQA uses the results of the child survey when calculating Medicaid plan rankings. Checkbook/CSS has seen strong correlation between the adult and child commercial survey results, but has less data on the relationship between the adult and child Medicaid survey results. There are many states that administer and report results from both Medicaid surveys, and DHS has noted that many consumers choose a managed care plan based on their children's experience with health care in that plan.

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<sup>1</sup> 2012-2013 NCQA Medicaid Plan Rankings.

<http://www.ncqa.org/Portals/0/Report%20Cards/Rankings/hpr2012medicaiddet.pdf>

<sup>2</sup> Preventable Chronic Conditions Plague Medicaid Population. Gallup.

<http://www.gallup.com/poll/161615/preventable-chronic-conditions-plague-medicaid-population.aspx>. Accessed 5/7/2013.

A variation of the Child Medicaid CAHPS survey that could also be considered for inclusion in the Medicaid QRS is the Child Medicaid CAHPS survey for Children with Chronic Conditions. This survey includes all of the measures in the Child Medicaid CAHPS survey but adds several measures addressing the care and services provided to children with chronic conditions.

*Working Decision Two: Assigning equal weights to QRS measures*

Past memos have presented weighting as an option to allow certain measures to be given greater or lesser weight in a composite score. DHS's working decision to assign all measures an equal weight is a common methodological practice. The decision of how to weight measures in the commercial QRS has not been made.

A decision on whether to weight the measures when combining into a composite might be moot if it is decided to maintain the existing CAHPS composite measures and not roll measures up into higher-level composites as in the proposed commercial QRS straw model (see *Working Decision Four*).

*Working Decision Three: No case-mix adjustment of QRS measures*

This decision is consistent with NCQA's practice of not adjusting CAHPS scores, despite the fact that the CAHPS consortium does recommend case-mix adjustment using variables such as age, education, gender, and health status (all of which can be obtained through the survey instrument itself).

Currently, the Minnesota Managed Care Public Programs' Adult Medicaid CAHPS survey results are case-mix adjusted for size of plans' Medicaid population, age and health status, so that managed care organizations with younger, healthier enrollees can be compared fairly to managed care organizations with older, less healthy enrollees<sup>3</sup>. Maintaining this current adjustment model for future CAHPS analysis would promote consistency with prior year reporting.

The working decision not to case-mix adjust the results is based on DHS's observation that the characteristics of managed care enrollees are very similar across plans. It would be possible to determine whether plans are different enough in their enrollee characteristics to justify case-mix adjustment. This could be done using prior year data to calculate case-mix adjusted scores and assessing the extent to which the case-mix adjusted scores differ from the unadjusted scores. If scores

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<sup>3</sup> 2011 Minnesota Managed Care Public Programs: Consumer Satisfaction Survey Results. July 2011. <http://www.dhs.state.mn.us/healthcare/studies>

are meaningfully affected by case-mix adjustment, then the demographic differences among plans might justify case-mix adjustment.

Because Medicaid plans will not be compared to commercial plans in the QRS, it is not necessary for the case-mix adjustment methodology to be consistent across the two rating systems. A decision has not yet been finalized regarding adjustment of CAHPS results for commercial products included in the QRS.

*Working Decision Four: Use Overall Rating of Health Plan rather than rolling up measures to an Overall Health Plan Quality score*

In the proposed commercial QRS, all measures roll-up to obtain an *Overall Health Plan Quality* composite score. This composite summarizes quality measures from a variety of sources (e.g. enrollee satisfaction, clinical quality, and quality of plan services). This score allows consumers to assess plan quality without having to drill down to the numerous proposed sub-composites and 74 individual measures. DHS is proposing to use the Overall Rating of Health Plan question as the Overall Health Plan Quality score, instead of rolling-up measures to arrive at an overall quality score. This approach is reasonable considering that the proposed Medicaid QRS is comprised of nine measures from the CAHPS survey, which are drivers of the Overall Rating of Health Plan measure (for example, if a respondent got care quickly, then the respondent is more likely to rate the plan favorably). No matter which overall quality score is chosen, the methodology for arriving at the score should be transparently displayed on the website, particularly for consumers who may view both the Medicaid QRS and Commercial QRS over time.

*Working Decision Five: Use a scoring methodology consistent with the commercial QRS*

The way in which measures are scored for the commercial QRS is still being finalized; however, all of the proposed methodologies from previous memos are compatible with the CAHPS measures, so that any of the proposed methodologies could be used for the Medicaid QRS. Since Medicaid and commercial plans will not be directly compared to one another in MNsure, the measures do not necessarily have to be scored in the same manner.

To ensure a similar shopping experience between Medicaid and commercial MNsure consumers, the most important element is how these scores will be *displayed* to consumers. For example, it has yet to be determined whether raw scores will be shown (e.g. 95%), or will be translated into a symbolic rating system (e.g. 4 stars). Regardless of the final decision on how scores will be displayed, ideally there

should be a consistent score display so that enrollees who are accustomed to comparing plans using one type of score do not have to acclimate themselves to an entirely new system at a later date if they switch between Medicaid and the commercial health plan products. This consistency would also be beneficial for navigators and other health care professionals who will help consumers choose plans.

If raw scores are displayed (as opposed to symbols), then there may be some comparability issues between Medicaid and the commercial QRS. For example, Medicaid CAHPS rating questions are currently scored as the proportion of respondents who rated the health plan a “9” or “10.” DHS desires to keep this scoring methodology because it is the federal reporting requirement and also allows the agency to trend to prior year scores. At the same time, the common scoring methodology for commercial plans is to present the proportion of respondents who rate the health plan an “8,” “9,” or “10.” Even though Medicaid and commercial plans will not be compared side-by-side, those consumers who switch from Medicaid to the commercial market may perceive Medicaid plans as performing more poorly than commercial health plans simply because the Medicaid CAHPS scoring is stricter than the commercial CAHPS scoring. DHS and most commercial users of CAHPS commonly use “Always” as the top box for ratings on a scale of “Never,” “Sometimes,” “Usually,” or “Always”; thus this reporting discrepancy is only a potential issue for 0-10 scale questions.

There may also be confusion among consumers who have had exposure to both the Medicaid QRS and the commercial QRS if the raw scores are calculated two different ways. For example, if one QRS uses mean scoring of CAHPS results, and another uses proportional scoring, then the score itself will look different. Neither method is incorrect, but using a different type of raw score in each QRS may present additional cognitive burden to consumers who churn between Medicaid and commercial products.

The calculation method for raw scores matters less if the scores are being translated into a symbolic rating system that is consistent across the Medicaid QRS and commercial QRS. Symbols are often used for ease of consumer interpretation. Symbols can vary in appearance (stars, up/down arrows, etc.) and in how much distinction among plans these symbols can create (e.g. 3-star system v. a 5-star system). For translating the scores into symbols, several options are being considered, including percentiles, significance testing, thresholds (that are not percentile-based), or a combination of methods. Consumers, in general, are less concerned with *how* the score gets translated into a symbol and more concerned with *what* the symbol represents at a high level. For example, a consumer can generally understand that 5 stars is “good” and 1 star is “bad,” but it is harder to understand that 5 stars means that the plan was in the top quartile of plans and performed significantly better than the state average.

The primary component of the commercial QRS that should be carried over to the Medicaid QRS should be that symbolic scores are presented in such a way that consumers can easily familiarize themselves with the rating system if they shift between Medicaid and commercial products over time. The symbols themselves can be consistent, even if the methodology behind creating the symbol is not. For example, the Exchange might decide that setting performance thresholds is the best way to translate raw scores into 1, 2, or 3 stars. DHS might decide that significance testing is the best way to translate raw scores into 1, 2, or 3 stars. The end product that consumers will see in both rating systems is a score from 1 to 3 stars. DHS might choose to use the same calculation methodology as the Exchange; however, depending on the number of participating plans and the variation in scores among those plans, a different approach might be more appropriate.

Handling of missing data is also a methodological issue that should be considered for the Medicaid QRS. HEDIS CAHPS measures must have a minimum of 100 responses in order to be considered reportable and the CAHPS consortium also recommends achieving 100 usable responses for public reporting. This recommendation is consistent across commercial and Medicaid plans. For the Minnesota Managed Care Public Programs Consumer Satisfaction Survey, sample sizes are designed to yield at least 300 returned surveys, which generally allows for reportable results on all survey measures. However, some Medicaid managed care organizations do not have adequate numbers of enrollees to draw a full sample and in prior years these plans have been combined and treated as a single reporting unit. That methodology will not work if the goal is to make comparisons among plans. If these plans do not have enough survey responses on their own to report results, then missing data will be an issue for the QRS. Any of the proposed methodologies from previous memos regarding treatment of missing data could be applied to the CAHPS measures.

### **Discussion**

- To what extent are the proposed commercial and public program quality rating systems sufficiently aligned?
- Which HEDIS measures do work group members suggest DHS select for the public program QRS supplemental information?