Measure Applications Partnership

Health Insurance Exchange Quality Rating System Task Force

Web Meeting

September 26, 2013

NATIONAL QUALITY FORUM

Welcome, Review of Meeting Objectives, Introductions/Disclosures of Interest

Agenda

- Welcome, Review of Meeting Objectives, Introductions/Disclosures of Interest
- Orientation to the Health Insurance Marketplace QRS
- Consider Health Plan Information Needed to Enable Consumer Decision-Making
- Opportunity for Public Comment
- Next Steps

Meeting Objectives

- Review task force charge, role within the MAP, and plan to complete tasks
- Review health insurance exchanges/marketplaces and Quality Rating System (QRS) background
- Consider health plan information available to consumers and define scope of MAP's input

Health Insurance Exchange (HIX) Quality Rating System (QRS) Task Force Membership

Workgroup Chair: Elizabeth Mitchell

Organizational Members

Academy of Managed Care Pharmacy	Marissa Schlaifer, RPh, MS
The Advanced Medical Technology Association	Steve Brotman, MD, JD
Aetna	Andrew Baskin, MD
America's Essential Hospitals	David Engler, PhD
America's Health Insurance Plans	Aparna Higgins, MA
American Association of Retired Persons	Joyce Dubow, MUP
American Board of Medical Specialties	Lois Nora, MD, JD, MBA
American Medical Group Association	Samuel Lin, MD, PhD, MBA, MPA, MS
Center for Patient Partnerships	Rachel Grob, PhD
CIGNA	David Ferriss, MD, MPH
Consumers' CHECKBOOK	Robert Krughoff, JD
Humana, Inc.	George Andrews, MD, MBA, CPE
Iowa Healthcare Collaborative	Lance Roberts, PhD
March of Dimes	Cynthia Pellegrini
Memphis Business Group on Health	Christie Upshaw Travis, MHSA
National Business Coalition on Health	Colleen Bruce, JD
National Partnership for Women and Families	Emma Kopleff, MPH
SNP Alliance	Chandra Torgerson, MS, RN, BSN
The Brookings Institute	Mark McClellan, MD, PhD

Health Insurance Exchange (HIX) Quality Rating System (QRS) Task Force Membership

Subject Matter Experts

Child Health	Richard Antonelli, MD, MS
Health IT	Thomas von Sternberg, MD
Measure Methodologist	Debra Saliba, MD, MPH
Medicaid ACO	Ruth Perry, MD
Nursing	Gail Stuart, PhD, RN

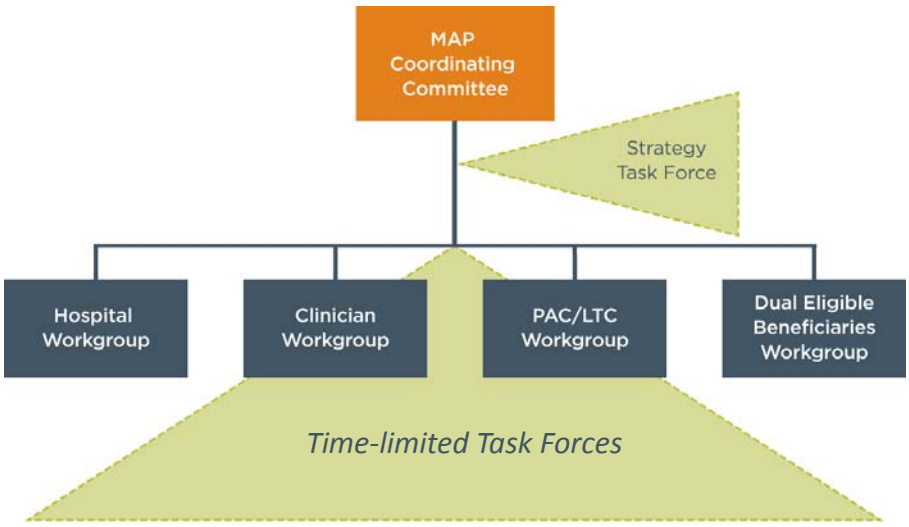
Federal Government Members

Centers for Medicare and Medicaid Services (CMS)	Deborah Green
Health Resources and Services Administration (HRSA)	Terry Adirim, MD, MPH

HIX QRS Task Force Charge

- Advise the MAP Coordinating Committee on recommendations for the hierarchical structure, organization, and measures for the child and family core sets of the QRS
  - MAP is not providing recommendations on the marketplace websites, materials, displays, or minimum benefits
  - The QRS' primary purpose is to inform consumer choice of Qualified Health Plans (QHPs) in the marketplaces
- The task force is time-limited and consists of current MAP members from the MAP Coordinating Committee and all MAP workgroups with relevant interests and expertise

MAP Structure



Timeline for HIX QRS Task Force Activities

September 26: Task Force Web Meeting	• Review task force charge, background of the QRS, and relevant populations • Consider health plan information available to consumers and define scope of MAP's input
October 18: Task Force Web Meeting	• Define the highest leverage measurement opportunities for the marketplace populations • Review the MAP Measure Selection Criteria (MSC) and consider how it will be used in marketplace QRS decision-making framework • Consider the ideal hierarchy and measurement domains for consumer decision-making
November: Task Force In-Person Meeting	• Develop recommendations and rationale regarding measures for inclusion in QRS • Develop recommendations and rationale regarding structure of QRS • Identify gaps in measure to enable consumer decision-making
December: Public Comment Draft Report	• Task force review of draft report via email • Report posted to NQF website for a two-week public comment period
January 7-8: MAP Coordinating Committee In-Person Meeting	• MAP Coordinating Committee review of public comment draft and public comments received • HIX QRS Task Force will be asked to join by phone • Finalize recommendations and rationale on measures for inclusion and structure of QRS
January: Final Report	• Submit final report to DHHS

MAP Input on the Marketplaces Quality Rating System

Final Report Outline

- Introduction
- Enabling consumer choice in healthcare marketplaces–the ideal state
  - Presenting information to consumers (structure, domains)
  - Providing meaningful information to consumers (high-leverage opportunities for measurement)
- Input on Marketplaces QRS
  - Input on QRS structure (structure, hierarchy, domains)
  - Input on proposed core child and family measures for the QRS
  - Identified measure gaps
- Path Forward
  - Addressing measure gaps
  - Changes to structure and hierarchy over time
  - Innovative directions
- Conclusion

Orientation to the Health Insurance Marketplace Quality Rating System

Overview of the Health Insurance Marketplaces and Quality Rating System

Statutory Authority

- Affordable Care Act (ACA) Sections 1311-1343 of Subtitle D of Title I
- National infrastructure to offer citizens health insurance through Affordable Insurance Exchanges or Health Insurance Marketplaces
- Marketplaces are designed to provide a place for individuals or small businesses to:
  - Search for health insurance coverage options and
  - Identify costs and benefits to health insurance coverage
- Marketplaces will provide information on health plans based on relative quality and price to individuals and employers through the QRS
  - Enrollee satisfaction information will be provided to individuals and employers on plans with more than 500 enrollees the previous year
- Two types of marketplaces:
  - Affordable Insurance Exchange (Individual Marketplace)
  - Small Business Health Options Program (SHOP Marketplace)

Overview of the Health Insurance Marketplaces and Quality Rating System

State and Federal Marketplaces

- States can choose to operate marketplaces in the opt-in model
- The federal government will automatically operate a marketplace (federally facilitated marketplace) in every state that does not opt to operate their own
  - Some states have been approved to develop independent marketplaces that meet federal requirements
  - Other states are creating a variety of partnerships to create marketplaces with the federal government
- The government operating the marketplace will be responsible for implementing four core exchange functions:
  - Eligibility and enrollment
  - Plan management
  - Consumer assistance, outreach, and education
  - Financial management
- Marketplaces are open for enrollment beginning October 1, 2013 with coverage beginning as early as January 1, 2014

Overview of the Health Insurance Marketplaces and Quality Rating System

Accreditation

- Health plans are required to be or become accredited
- Accreditation includes considerations of local plan performance on:
  - Clinical quality measures, such the Healthcare Effectiveness Data and Information Set (HEDIS)
  - Patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey
  - Programs on consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information
- DHHS has so far recognized two accreditation entities for certification of qualified health plans
  - NCQA
  - URAC

http://www.ncqa.org/Programs/Accreditation/HealthPlanHP.aspx
https://www.urac.org/policyMakers/resources/URACHealthReform20110928.pdf

Overview of the Health Insurance Marketplaces and Quality Rating System

QRS Structure

- Public reporting of quality information will be required to meet health plan requirements for participation in marketplaces
- In previous rulemaking, DHHS has indicated that the QRS structure will be established in future rulemaking

Overview of the Health Insurance Marketplaces and Quality Rating System

Population Description

- Over 47 million non-elderly uninsured people in the US (aged 0-64)
  - Approximately 17 million of them will be newly insured in 2014
  - 90% of individual marketplace enrollees will receive federal subsidies
  - Total marketplace population is projected to reach 29 million in 2021
  - Median age expected to be 33, more than 50% expected to be unmarried
  - Marketplace population is anticipated to have a median income of 166% of FPL, compared to the currently insured with medium income of 333% FPL
- Approximately 40% of the expected individual marketplace enrollees will come from five states: California, Texas, Florida, New York, and Illinois
- Marketplaces are anticipated to be more ethnically diverse than the currently insured population

Overview of the Health Insurance Marketplaces and Quality Rating System

Population Description

- 90% of children in the US have either public or private health insurance coverage
- Uninsured rates among young adults continue to remain high compared to other age groups
- Individuals without a high school degree are less likely to be currently insured and will make up a majority of the newly insured population
- The marketplace population is less likely to report excellent or very good health than the traditional market

Consider Health Plan Information Needed to Enable Consumer Decision-Making

Defining MAP's Input

What information do consumers and small employers need to select health plans?

- Existing health plan-level quality measures (e.g., HEDIS, CAHPS) that have been traditionally used in health plan reporting programs?
- Information purchasers have required of health plans (e.g., cost sharing, provider measurement and rewards)?
- Provider-level quality information on clinicians and facilities within plans' networks?
- Direct consumer commenting (e.g., reviews, experience)?
- Other?

What Quality Information is Necessary to Enable Consumer Decision-Making?

Health Plan Functions

- Network Management
  - Contract with providers and facilities
  - Maintain adequate services and access
- Benefit Design
  - Services for members
  - Incentives for members
- Care Management
  - Prevention, treatment, and disease management programs
  - Care coordination across multiple clinicians and facilities
- Provider Payment
  - Claims adjudication
  - Incentives for providers
- Customer Service
  - Member information
  - Complaints
- Other?

What Quality Information is Necessary to Enable Consumer Decision-Making?

Previous Findings Regarding Consumer Choice of Exchanges

- Information should be able to be interpreted "at-a-glance"
  - High-level synthesized quality information with opportunities to drill down
- Need strong decision-making information and tools about key issues including cost, quality, and participating providers
- Consider how information is interpreted by consumers
  - Different populations using marketplaces will have different priorities
  - Consumers are reluctant to choose low-cost options, even when high-quality

What Quality Information is Necessary to Enable Consumer Decision-Making?

Previous Findings Regarding Consumer Choice of Exchanges

- Provide information on features valued by consumers
  - Provider choice, including self-referral to a specialist
  - Access to care when needed
  - Costs
  - Additional benefits (health and wellness programs, dental and vision benefits)
  - Plan administration
- Quality Measures
  - Experience, quality, and cost should be equally prominent
  - Use endorsed measures (particularly HEDIS and CAHPS)
  - De novo measures may be needed
  - Integrate complaints and grievances information with all performance information

What Quality Information is Necessary to Enable Consumer Decision-Making?

Health Plan Information

- Accreditation and Recognition Programs
  - URAC, The Joint Commission, Accreditation Association of Ambulatory Health Care, Accreditation Commission for Health Care (Home Health and alternate site providers), etc.
- Structured Rating and Ranking Systems
  - Medicare Star programs, NCQA/ConsumerReports, JD Power, U.S. News, etc.
  - Stars, points, ranks from surveys, standards, and reported data on health plans, hospitals, nursing homes, etc.
- Consumer Direct Commenting
  - HealthGrades, Angie's List, WebMD, ZocDoc, Healthline, etc.
  - Locations, hours, affiliations, impressions, experiences, etc.

What Quality Information is Necessary to Enable Consumer Decision-Making?

NCQA and Consumer Reports

- Publish health plan quality ratings
- Plans can choose not to publicly report quality information
- Overall score consists of scores of three domains
  - HEDIS (60%), CAHPS (25%), Accreditation (15%)
  - Ratings of Commercial, Medicaid, and Medicare plans
- Data collected through submissions to CMS (HEDIS and CAHPS) or NCQA accreditation surveys
  - Measure not included in rating if less than half of plans report
  - Plans with fewer than 8,000 enrollees are not included

What Quality Information is Necessary to Enable Consumer Decision-Making?

Medicare Star Ratings

- Ratings of health plans and drug plans
  - Ratings of overall score and by each domain
  - Ratings of benefit and estimated (base) cost
- Scores based on 53 measures
  - Prevention and treatment, enrollee satisfaction, benefits management, and cost
  - Medicare plan ratings include total estimated costs, monthly premiums, drug premiums, copays, and in- and out-of-network costs

What Quality Information is Necessary to Enable Consumer Decision-Making?

eValue8

- National report on overall health plan performance
  - Member dues allow access to health plan performance
  - Ratings of 57 plans and rankings of top 5 HMOs and PPOs
  - Commercial plans voluntarily participate by submitting surveys
- Annual report shows health plan performance on 8 elements of eValue8
  - Measures of prevention and treatment, enrollee satisfaction, benefits management, and cost
  - Cost elements include cost control, plan value, and waste

Catalyst for Payment Reform

- Adds payment reform questions to eValue8 survey:
  - National results; California will have additional report
  - Commercial dollars paid, characteristics of payment reform environment, plan member reach, provider participation, building blocks of payment reform, and quality indicators

What Quality Information is Necessary to Enable Consumer Decision-Making?

Examples of Health Marketplace Quality Rating Systems

- 11 state-operated marketplaces have plans to display health plan quality information prior to the federal deadline
  - Nine states have indicated they plan to display quality information in 2014
  - Two states, New Mexico and Washington, plan to display quality information in 2015
- 6 states and the District of Columbia do not plan to display health plan quality in the marketplaces prior to the federal requirement in 2016
- Nevada has not yet determined whether it will display quality information prior to the federally required deadline in 2016

MAP Framework for Aligned Performance Measurement: National Quality Strategy

- Working with communities to promote wide use of best practices to enable healthy living
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease
- Ensuring that each person and family are engaged as partners in their care
- Making care safer by reducing harm caused in the delivery of care
- Promoting effective communication and coordination of care
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models

What Health Plan Information Is Most Important to Enable Consumer Decision-Making?

National Quality Strategy

- Health and Well-being
  - Health promotion programs, behavioral health management
- Prevention and Treatment of Leading Causes of Mortality
  - HEDIS, clinical outcomes, disease management
- Person- and Family-Centered Care
  - CAHPS, HCAHPS, consumer engagement
- Patient Safety
  - Safety indicators, risk-adjusted mortality, hospital complications, never-events
- Effective Communication and Care Coordination
  - CAHPS, HCAHPS
- Affordable Care
  - Plan benefit and cost rankings, coverage features, value, payment reform characteristics

Defining MAP's Input

What information do consumers and small employers need to select health plans?

- Existing health plan-level quality measures (e.g., HEDIS,CAHPS) that have been traditionally used in health plan reporting programs?
- Information purchasers have required of health plans (e.g., cost sharing, provider measurement and rewards)?
- Provider-level quality information on clinicians and facilities within plans' networks?
- Direct consumer commenting (e.g., reviews, experience)?
- Other?

Opportunity for Public Comment

Next Steps

Future Meetings

- Web Meeting: **October 18**
- In-Person Meeting: **November, days TBD**
- Public Comment Review: **December, days TBD**

Adjourn