MEMO

To: **COHBE Board**

From: **COHBE Staff**

Subject: Quality Display and Data Collection

Date: **March 11, 2013**

Background:
On 9/24/12, the board voted to provide quality information on the exchange, and on 10/18/12, the board decided that that information would include a CAHPS (customer satisfaction survey) "composite rating" and link to HEDIS (clinical quality information) information as well as other appropriate metrics about health plan quality.

Operational Implementation:

After reviewing the current state of quality and accreditation and the available metrics, staff is recommending the following quality information be displayed for each carrier product type (i.e. HMO and PPO):

- For the shopping page: **Overall Rating of Health Plan** (Note: this is not a composite rating – this will be further discussed later in this memo)
    - This would be displayed as 1-3 or 1-5 stars based on the health plans performance in the 8,9,and 10 categories (interpreted by NCQA as corresponding to somewhat satisfied, satisfied, or very satisfied)
        - **Three stars**: for example in 2011, national average for HMOs was 66.1%, 10th percentile was 52.5% and 90th percentile was 78.2%. Plans that were below half the distance between the 10th percentile and the median (< 59.3%) would get one star, equal or greater than 59.3% would get two stars, and above half the distance between the 50th and the 90th percentile (> 72.2) would get three stars.
        - **Five stars**: for 5 stars based on 2011 data, numbers would look like this:
            - < 52.50 %: one star
            - >=52.50 - 59.30%: two stars
            - > 59.31% - 66.10%: thee stars
            - >66.10% - 72.20%: four stars
            - > 72.20: five stars
        - **Combined AG Feedback**: Support for both options. Many felt that a "5 star" display was more typical, consistent with Medicare Advantage program, Amazon ratings, etc. Others were concerned that displaying results in five stars implied a level of granularity and detail that was not consistent with the data.
            - **Staff Recommendation**: display in five stars to be consistent with what consumers are used to seeing.
        - Plans that do not have CAHPS results available will have "In Progress" displayed.

- On the "link" quality page the following data will be displayed (note: this page will be displayed in English and Spanish). Carriers that are offering both PPO and HMO plans will submit this information separately for each product. The appropriate page will be linked to the similar type of QHPs (e.g., PPO quality data will be tied to PPO QHPs):
    - **Accrediting agency:** NCQA or URAC. Of the 12 carriers anticipated to participate in the exchange, eight are or will be accredited by NCQA, and four are pursuing URAC accreditation (See addendum)
    - **Accreditation Type:** Most carriers will have "Health Plan" accreditation, but for those with health plan accreditation *In Progress* who have partial accreditation (such as case management or disease management accreditation through URAC,) that will be displayed
    - **Accreditation Status** (those not yet accredited will show as "in progress")
        - The currently accredited plan must be similar to the relevant exchange product (i.e. a commercial HMO or PPO in Colorado)
    - **Detailed Ratings** for those plans that are currently NCQA Accredited.
        - This is a summary rating developed by NCQA that aggregates results from standards review and HEDIS; It is updated annually
        - Categories include: *Access and Services, Qualified Providers, Staying Healthy, Getting Better, Living With Illness*
        - We plan to license this information for 2012 results (reported in 2013) directly from NCQA
        - URAC does not have a similar aggregate rating and does not currently plan to develop one
    - **Consumer Complaints Index**: This will be obtained directly from the DOI
    - **Free Text Section**: To give consumers the opportunity to learn what makes each carrier unique in the quality area, each carrier will be asked to submit answers to three questions (note: carriers should be prepared to submit response in both English and Spanish):
        - **How the health plan works to make members healthier** (limited to 200 words)
        - **How the health plan works with providers in innovative ways** (limited to 200 words)
        - **Examples of innovative approaches to health** (limited to 200 words)
    - **HEDIS Metrics:**
        - We anticipate collecting 2011 results directly from carriers (as reported in 2012), and hope to purchase 2012 results directly from NCQA in September and load on the exchange site prior to open enrollment.
        - It is yet to be determined how data from carriers that are pursuing URAC and fielding a CAHPS survey in 2013 will be obtained (URAC can not commit to transmitting data directly to the exchange.)
        - The following HEDIS (CAHPS and Effectiveness of Care) metrics will be displayed:
            - *Overall Rating of Health Care (CAHPS)*
            - *Health Plan Customer Service (CAHPS)*
            - *Ease of Getting Needed Care (CAHPS)*
            - *Cholesterol Control in Patients with Cardiovascular Conditions (Cholesterol < 100)*
            - *Percent of Women Receiving timely prenatal care*
            - *Childhood Immunization Status - Combo 2*

        - *Cervical Cancer Screening*
        - *Colorectal Cancer Screening*
        - *Control of Blood Pressure in Patients with Diabetes (BP < 140/90)*
        - *Control of LDL-C in Patients with Diabetes (LDL < 100)*
        - *Plan All-Cause Readmissions*
        - *Use of Imaging Studies for Low Back Pain*
    - Clinical HEDIS results will be compared to regional and national benchmarks.
    - CAHPS data will be compared to national average and 90th percentile.
        - CAHPS data from plans pursuing URAC accreditation will be compared to the same NCQA benchmarks since URAC benchmarks are not yet developed.
- On the "link" page, plans in different states of accreditation and using different accreditation agencies will have different data included. For those plans that have data pending, an icon with explanatory text will be used. An example may look like the following:

- **Combined AG Feedback**:
    - General agreement with the HEDIS metrics and other elements to be displayed. Carriers and consumers both like the free text sections.
    - There was a comment asking for trending over time. This will be explored for 2015 open enrollment display. There was some concern about the display overall, especially that the PDF format would be confusing and difficult to maneuver for consumer. COHBE will work with its web developers to try and make the page navigation as simplified as possible.

Other Considerations:

- **MLR**: we had originally proposed displaying the previous year's MLR for consumers on the quality page. Instead that will not be displayed on the "health plan summary" page.
    - Combined AG feedback*:* some consumer concern that consumers would not know to go to the health plan summary page for data like this.

Discussion of the "Composite" issue:

- At the October board meeting, the board voted to display a CAHPS composite on the shopping page. Conversation during the board meeting revolved around the question of how to measure overall member satisfaction with the health plan, and we believe that was the intent. However, on further investigation, there is no CAHPS composite that reflects this. The only CAHPS metrics that are "composites" (i.e. composed of more than one survey question) are listed in the appendix. It is our belief that none of these metrics are more representative of the overall performance of the carrier than the "Overall Rating of Health Plan" question.
    - Combined AG feedback: General agreement that this was indeed the intent and that the *Overall Rating of Health Plan* was a reasonable alternative measure.

Discussion of Data Collection

- COHBE proposes the following attestations as part of the quality data submission:
    - We attest that our CAHPS survey was administered by a certified vendor.

- We attest that our quality data has been audited by a qualified 3rd party, consistent with industry standards.
- We certify and attest that we currently have in place a quality improvement strategy consistent with the standards of section 1311(g) of the Affordable Care Act (ACA).
- We attest that we will disclose and report information on health care quality and outcomes as described in section 399JJ of the Public Health Services Act, in alignment with the benefits offered by the QHP.
- We attest that we will report to HHS and the Exchange, at least annually, the pediatric quality reporting measures described in section 1139A of the Social Security Act, in alignment with the benefits offered by the QHP.
- We attest and confirm that we will conduct enrollee satisfaction surveys consistent with the requirements of section 1311(c) of the Affordable Care Act.

- For those carriers that do have NCQA data, the data that was self-attested will be updated with the data received directly from NCQA.

- **Combined AG feedback**
  - There was a concern that some carriers that were intending to submit "self-audited" data would be required to hire an independent auditor to meet these requirements. COHBE feels that auditing by a 3rd party vendor is required to ensure accurate data comparisons.
  - There has also been a request for clarification of the provisions required by the ACA. We have spoken with contacts at CMS/CCIIO. They have not yet promulgated regulations and do not intend to audit carriers until 2016. At this point COHBE would ask plans to interpret these provisions to be best of their abilities and attest that they believe they are in compliance.

Display Considerations:

- Three illustrative design samples were shared with the group for directional feedback.
- The designs must be updated to reflect the updated COHBE brand.
- The design samples are only intended to provide directional design concepts and do not reflect the final design.
- The designs can be found for reference in the additional attachment.
- **Combined AG feedback**
  - There was consensus that the "Consumer Complaints Index" display was confusing; it is not clear if it is better to have a "high index" or a "low index". Staff will attempt to make this easier to understand and will consider adding raw numbers of complaints.
  - The group liked the "tabular" layout (page 1 of the attachment) that allows the consumer to see the different types of data available in a single glance but not overwhelming the consumer with too much information.
  - It was noted that using a PDF instead of a webpage to display this data is not as optimal for the consumer experience.
  - There is also a strong preference to be a need for the page to be printer friendly.

Addendum

Carrier	Plan Status	Accrediting Body	Accreditation Completed?	CAHPS Data Availability 10/1/13	NCQA Composite Availability 10/1/13	Quality Metrics Availability 10/1/13	Data Source
Kaiser	National	NCQA	Complete	Yes	Yes	Yes	NCQA
Anthem	National	NCQA	Complete	Yes	Yes	Yes	NCQA
CIGNA	National	NCQA	Complete	Yes	Yes	Yes	NCQA
Humana	National	NCQA	Complete	Yes	Yes	Yes	NCQA
UHC	National	NCQA	Complete	Yes	Yes	Yes	NCQA
RMHP	Regional	NCQA	In Process	Yes	No	Possibly	Plan Audited
Colorado Choice	Regional	NCQA	In Process	Possibly	No	Possibly	Plan Audited
Denver Health	Regional	NCQA	In Process	Possibly	No	Possibly	Plan Audited
SeeChange Health	Regional, new to Colorado	URAC	Partial, Health Plan in process	Possibly	Never	Possibly	Plan Audited
Colorado Access	Regional, new to commercial market	URAC	In Process	No	Never	No	No commercial data
CO-OP	Regional, new to Colorado	URAC	Partial, Health Plan in process	No	Never	No	No data

CAHPS Metrics Composed of more than one CAHPS question
with Feeder Questions

- Getting needed care (Q14 and Q25)
  - Q14: In the last 12 months, how often was it easy to get the care, tests, or treatment you needed?
  - Q25: In the last 12 months, how often did you get an appointment to see a specialist as soon as you needed?

- Getting care quickly (Q4 and Q 6)
  - Q4: In the last 12 months, when you needed care right away, how often did you get care as soon as you needed?
  - Q6: In the last 12 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?

- How well doctors communicate (Q17, Q18, Q19 and Q20)
  - Q17: In the last 12 months, how often did your personal doctor explain things in a way that was easy to understand?
  - Q18: In the last 12 months, how often did your personal doctor listen carefully to you?
  - Q19: In the last 12 months, how often did your personal doctor show respect for what you had to say?
  - Q20: In the last 12 months, how often did your personal doctor spend enough time with you?

- Customer service (Q35 and Q36)
  - Q35: In the last 12 months, how often did your health plan's customer service give you the information or help you needed?
  - Q36: In the last 12 months, how often did your health plan's customer service staff treat you with courtesy and respect?

- Claims processing (Q40 and Q 41)
  - Q40: In the last 12 months, how often did your health plan handle your claims quickly?
  - Q41: In the last 12 months, how often did your health plan handle your claims correctly?

- Shared decision making (Q10, Q11, and Q12)
  - Q10: When you talked about starting or stopping a prescription medicine, how much did a doctor or other health provider talk about the reasons you might want to take a medicine?
  - Q11: When you talked about starting or stopping a prescription medicine, how much did a doctor or other health provider talk about the reasons you might not want to take a medicine?
  - Q12: When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you?

- Plan information on costs (Q31 and Q33)
  - Q31: In the last 12 months, how often were you able to find out from your health plan how much you would have to pay for a health care service or equipment?
  - Q33: In the last 12 months, how often were you able to find out from your health plan how much you would have to pay for specific prescription medicines?