Roadmap for Implementing Quality Requirements: Recommendations for Vermont's Health Benefits Exchange

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1. Background

This is the final in a series of reports on integrating quality into the Vermont Health Benefits Exchange (Exchange) prepared by the University of Massachusetts Medical School (UMMS). This report summarizes and synthesizes information from previous reports. The specific contract language regarding this deliverable is presented in Appendix 1.

This report begins with a recap of the ACA and Act 48 requirements. Next we review Vermont strengths and gaps with respect to accreditation, quality measurement, experience with summary rating systems, and quality improvement. Third we present implementation recommendations for the Exchange in three broad areas:

1. Integrating quality into the certification process
2. Reporting quality information to consumers
    a. Choosing metrics – lessons from the quality inventory
    b. Strategies for acquiring and auditing the data
    c. Benchmarking
    d. Creating summary scores
    e. Displaying results – lessons from reporting to consumers
3. Ongoing monitoring of QHPs

2. ACA and Act 48

Previous reports have described the ACA and Act 48 requirements with respect to quality. We summarize the key points below.

Public reporting to consumers. The ACA requires public reporting of two types of quality information: (1) quality relative to other plans (effectiveness of care performance ratings); and (2) enrollee satisfaction survey results.[1] The goal is to allow consumers to easily compare the QHPs available through the Exchange. Vermont's Act 48 also includes requirements related to consumer reporting. It directs the Exchange to provide "consumers and health care professionals with satisfaction surveys and other mechanisms for evaluating" QHPs.[2]

Summary ratings of QHPs. An Exchange must summarize comparative quality information for consumers to assist in the choice process. The ACA does not require an Exchange to include wellness activities into the quality ratings that Exchanges must apply in the future. Act 48 makes wellness a key feature of the rating system planned for Vermont, going so far as to call the future Vermont system a "quality and wellness rating."[3]

[1] ACA Section 1311(d)(4)(C), later 45 CFR Part 155.205(b).
[2] Act 48, Section 1805(13).
[3] ACA, Section 1311(c)(3); Act 48, §1805(5).

Incentives to improve quality. The ACA requires QHPs to design strategies that reward improvements in quality, especially for improvements in health outcomes, preventing hospital readmissions, improving patient safety and reducing medication errors, implementing wellness and health promotion activities, and reducing disparities.[4] These strategies must then be reported to the applicable Exchange and the Exchange is tasked with evaluating the strategies.[5]

Quality improvement activities. As enumerated in the previous paragraph, the ACA favors selected quality improvement activities. Vermont's Act 48 and Rule H-2009-03 have already established the principle that plans engage in "joint quality improvement activities" with other plans.[6]

3. Gap Analysis

Below we summarize the gap analysis presented in our *Inventory of Quality Activities in Vermont* (*Quality Invento*ry), organizing the information by the three major mechanisms for promoting quality that are available to an Exchange: certification, quality ratings and ongoing monitoring of health plan performance. Overall, Vermont is well positioned to implement a Health Insurance Exchange in terms of the ACA and state requirements for quality and quality reporting.

3.1. Quality requirements related to certification of qualified health plans

Entities wishing to offer products through the Exchange must be certified by the Exchange. The three ACA-related quality requirements for QHPs are accreditation, reporting quality (performance) information to Exchanges and reporting quality improvement strategies to Exchanges.

3.1.1 Accreditation

Health Insurance Exchanges must ensure that QHPs are "accredited with respect to local performance on clinical quality measures," within a timeframe established by the Exchange.[7] The federal legislation specifically names the HEDIS® measures and the CAHPS® surveys, as required by national accreditation organizations such as NCQA or URAC, in addition to other types of information. Vermont's Act 48 does not impose any additional accreditation requirements. However, Rule H-2009-03 includes additional state requirements for consumer protection as well as quality requirements for health plans, including additional reporting activities, which should also be considered for accrediting QHPs by the Exchange.

All health plans subject to Rule H-2009-03 and operating in Vermont have NCQA accreditation. In addition, many Vermont providers exceed minimum ACA requirements by securing additional

4 ACA Sec 1311(g)(1)
5 45 CFR Part 155.200(f)
6 Act 48, Section 1806(c)(2).; Vermont Rule H-2009-03, part 6.3 (D), pp. 65-66.
7 ACA, Section Sec. 1311(c)(1)(D)).

certification and recognition. For example, providers who have achieved NCQA's medical home certification may participate in the Blueprint for Health.

3.1.2. Reporting quality information

The ACA requires health plans seeking "qualified" status to report quality (performance) measure information and enrollee satisfaction information to their own enrollees, prospective enrollees and the Health Insurance Exchange. Each of the four major health plans in Vermont (Cigna, MVP, BCBS and TVHP) participates in HEDIS and CAHPS measurement as a requirement of NCQA accreditation and Rule H-2009-03 on an annual basis. These data are reported not only to NCQA but also to the Department of Financial Regulation for its annual Health Plan Report Card for consumers and the Annual MCO Data Filing Evaluation Report. In addition, all four plans are required to report quality performance information to their members upon request.

3.1.3. Reporting on quality improvement and incentive strategies

To become certified, prospective issuers must implement and report on their quality improvement strategies; and develop and implement strategies that provide increased reimbursement or other incentives for improving the quality of care to members. Vermont also requires potential issuers to engage in joint quality improvement activities with other plans, including with their mental health and substance abuse delegates. All major plans currently undertake multiple quality improvement initiatives and both the state and the plans use QI to incent higher performance.

3.2. Quality Information for Plan Selection

The Health Insurance Exchange is required to provide consumers and employers with two types of quality information: quality relative to other plans (performance ratings) and enrollee satisfaction survey results. The goal of presenting this information is to allow consumers to easily compare the QHPs available through the Exchange.

Vermont's measurement landscape provides ample opportunity for a rich and expanded measure set for reporting information to consumers. On the other hand, Vermont should proceed carefully and cautiously in making decisions about quality ratings.

Vermont health plans already collect and report CAHPS information. In addition, Vermont hospitals, home health agencies and nursing facilities report applicable CAHPS data to CMS for the various Compare websites. Other surveys are routinely conducted by the Vermont Department of Health (tobacco, BRFSS, physician) and the Vermont Department of Mental Health (consumer satisfaction). It is likely that the minimum federal requirements for consumer experience reporting will focus on Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys.

3.3. Ongoing Monitoring of QHP Performance

The ACA describes three core responsibilities for Exchanges related to plan monitoring:[8]

- Oversight of the enrollee satisfaction survey for each health plan that has more than 500 enrollees,
- Monitoring of complaints and appeals, and review of health plan data, including disenrollment and the number of denied claims, and
- Evaluation of QHP quality improvement strategies and providing incentives based on the results of these strategies.

Vermont rules already require extensive annual reporting on all dimensions of plan quality. Vermont health plans already collect CAHPS member satisfaction survey data, as well as provider satisfaction data mandated by Act 48 and Rule H-2009-03. To permit comparisons between plans, MCOs are required to include DFR-approved questions to their provider satisfaction surveys. In addition to satisfaction survey data, plans report on care quality (HEDIS), and on administrative measures that may affect both satisfaction and quality. These operational measures include service access indicators, utilization management activities, member disenrollments, and member grievances.

While the ACA lays out a broad vision of using "market-based incentives" to encourage health plan QI activities,[9] the details await future HHS rulemaking. The key point of clarity to date is that incentives will function at the plan level, through reimbursement policies. Act 48 links any incentive aimed at reducing costs to "maintaining or improving health outcomes and patient consumer satisfaction." No matter the incentive structure selected, care must be taken to avoid unintended consequences such as providers avoiding sicker patients.

4. Recommendations for quality components to be implemented by the Exchange

The ACA requires Exchange planners to make decisions about:

1. Quality and wellness data to be required for certification
2. Quality and wellness metrics to display on the Exchange's website
3. Metrics to be used in constructing summary ratings of QHPs
4. Sources of data for quality reporting
5. Benchmarking strategy
6. Methods for calculating composite ratings

These topics are discussed below along with recommendations for implementation.

[8] ACA Section 1311 (c) and (e).
[9] ACA Section 1311(g).

4.1 Quality and wellness data for certification

Recent federal proposed rulemaking identifies NCQA and URAC as the two federally acceptable agencies for accrediting QHPs. In addition, the rulemaking proposes that the accreditation should be at the product level, e.g. HMO, PPO, etc. Section 156.275(2)(iii) of the proposed rule states: "Recognized accrediting entities must provide accreditation at the Exchange product type level." The summary section of the proposed regulation is more explicit: "….we propose that recognized accrediting entities provide separate accreditation determinations for each product type offered by QHP issuers in each Exchange (for example, Exchange HMO, Exchange point of service (POS), and Exchange PPO)."[10] Both NCQA and URAC have extensive and rigorous processes for assuring quality as part of their accreditation programs.

> **Recommendation:** The Department of Financial Regulation currently certifies insurers and insurance plans in Vermont using a standard that includes NCQA and URAC accreditation and additional state requirements for consumer protection and quality requirements (including wellness). This is a higher standard than required by the ACA and should be maintained for certifying QHPs. Existing certified products should be grandfathered as QHPs. If final federal rulemaking requires QHP accreditation by product, then Vermont may need to tweak its certification process.

4.2 Choosing metrics – lessons from the quality inventory

Choosing metrics for display on the Exchange website involves at least three decisions: which quality and wellness domains should be represented, what measures within the domain should be selected, and the appropriate reporting level, e.g. plan or provider.

4.2.1 Measure Domains

The *Quality Inventory* documents that Vermont health plans and state agencies already collect measures in multiple domains:

- Access and availability
- Prevention and screening
- Care coordination
- Chronic condition management
- Health outcomes
- Behavioral health
- Pediatric care
- Service utilization
- Cost of care
- Patient experience
- Provider experience

[10] p. 33142 and 33137 of Federal Register, June 5, 2012 Vol 77 (108).

The processes that are currently in place and required under Rule H-2009-03 will continue to provide data that the Exchange can leverage to fulfill its ACA-mandated requirements.

Our paper on *Best Practices in Publically Reporting Quality Information to Consumers* (*Reporting to Consumers)* found that consumers are naturally drawn to measures of patient experience and have more difficultly relating to and understanding clinical measures. One strategy that works well with consumers is using easy to understand domain categories such as "Staying Healthy," or "Living with Chronic Conditions." This strategy is already being used by Vermont's Department of Financial Regulation for their annual Health Plan Report Card. Vermont's report card uses the domains of:

- Experience of Care and Service
- Preventive Care
- Acute Illness Care
- Chronic Illness Care

The Medicare Advantage report card eliminates the "acute illness care" domain and adds two domains - member complaints and health plan customer service (incorporated into Vermont's experience of care domain):

- Ratings of Plan Responsiveness and Care
- Member Complaints, Problems Getting Services, and Choosing to Leave the Plan
- Health Plan Customer Service
- Staying Healthy
- Managing Chronic Conditions

A third domain structure is provided by the National Quality Strategy, released in April 2011. The National Quality Strategy focuses on three areas: better care, healthy people and communities and affordable care. The National Quality Forum and CMS are both in the process of aligning their measurement domains with the Quality Strategy's six priorities:

National Quality Strategy Measure Domain	**Sample measures**[11]
Safer care	• Hospital acquired infections • Medication adverse events
Person- and caregiver- centered experience and outcomes	• Patient experience • Family experience • Caregiver experience

[11] 2012 Annual Progress Report to Congress. National Strategy for Quality Improvement in Health Care. April 30, 2012. Accessed at http://www.ahrq.gov/workingforquality/nqs/nqs2012annlrpt.pdf : 22 July 2012. See also CMS' quality measurement strategy http://www.iom.edu/~/media/Files/Activity%20Files/Quality/VSRT/Roundtable%20Meetings/March%2014%202012/Conway.pdf accessed 22 July 2012.

Care coordination	• Transitions of care • Admission and readmission measures • Provider communication
Prevention and treatment of leading causes of mortality	• Acute care • Chronic care • Clinical efficiency and utilization
Population and community health	• Preventive services • Health behaviors • Access to care • Treatment for depression and substance abuse
Affordable care	• Per capita expenses

Recommendation – Standard Domains: We recommend that the Exchange report measures in groups using standard domains such as those currently used by the Department of Financial Regulation or by the National Quality Strategy.

4.2.2 Measure Selection

Vermont stakeholders interviewed for the *Inventory of Quality Activities in Vermont Report (Quality Report)* report indicated a strong preference for using nationally recognized measures such as NCQA/HEDIS or measures endorsed by the National Quality Forum (NQF), especially for public reporting. HEDIS measures are widely known and accepted for measuring and comparing quality of care between health plans and providers. In addition, Vermont Rule-H-2009-03 requires standardized reporting by MCOs on selected quality of care measures using the HEDIS measure set and CAHPS survey to assess health plan member satisfaction.

The Vermont Exchange may wish to consider combining measures from different care settings in a single report of health plan quality, e.g. primary care setting, hospital setting, and home health setting. Currently, the report cards issued by the Department of Financial Regulation report metrics by setting, e.g. hospital and health plan. CMS's various Compare websites continue the practice (hospital, nursing home, home health). CMS's two core measure sets, for children (CHIPRA) and for Medicaid adults, include measures that cross settings. For example, in the prevention and health promotion domain, adult asthma admission rate is included as a potentially preventable hospitalization. Consumers who purchase insurance will be seeking care in multiple settings.

Recommendation – Measure Selection: For purposes of reporting to and through the Exchange, we recommend using nationally-recognized measures, preferably NQF-endorsed, for the following reasons:

- Measures are standardized and incorporate evidence-based practices
- Measures endorsed by NQF have been well tested
- In the case of HEDIS, measures are audited each year by external NCQA-certified auditors

Recommendation – Measure Slate: Vermont's current Health Plan Report Card represents an excellent starting point for the Exchange's operation. Three suggestions for 2014:

(1) Consider making the wellness measures more robust by adding stronger health promotion measures such as NQF #421's Adult BMI measure which provides for weight counseling since the currently reported HEDIS® measure for Adult BMI Assessment only includes BMI documentation. Because this is not a standard HEDIS measure, the state would need to consider the trade-off between data collection burden and the value of the resulting information.

(2) Supplement the traditional measures with the metric which identifies what proportion of the plan's providers are Blueprint medical homes. This will give consumers a more rounded view of a health plan. Keep in mind however, that this metric has value only as long as medical homes are not universal in Vermont.

(3) Consider adding links to measures from other settings, e.g. the hospital, home health, and nursing facilities.

4.2 3 Level of reporting

Vermont's public report cards offer information about plans and about individual hospital providers. Medicare's public reporting system displays provider level results for hospitals, nursing homes and home health agencies, and plan level results for Medicare Advantage plans. Although it is logical and reasonable to present quality and wellness results at the plan level since consumers are selecting QHPs, our *Reporting to Consumers* paper shows that consumers find measures at a granular level much more useful. Consumers want to know how their personal doctors, hospitals, nursing homes, etc. are doing in comparison to others

Recently released proposed federal rulemaking on accreditation requires QHPs to share clinical quality measure results and the adult and child CAHPS measure survey results with the Exchange, "at the level specified by the Exchange."[12] The preamble to the proposed rule clarifies that this means either at the QHP or plan level however, medical home entities submit HEDIS data to NCQA at the provider level. To the extent that Vermont wishes to encourage providers to become medical homes, the state may wish to consider requiring provider-level reporting in the future using HEDIS-CG (clinician group) and CAHPS-CG with the PCMH (patient-centered medical home) supplemental questions.

Recommendation – Level of Reporting: For initial operation (2014 - 2016) we recommend reporting only plan-level measures.

[12] 45 CFR 156.275(c)(5)(v), June 5, 2012.

4.3 Acquiring the data

As described in the *Inventory of Quality Activities in Vermont Report (Quality Report)*, the Exchange is uniquely positioned in a state that already maintains a robust data reporting system. The processes for submitting data to the Department of Financial Regulation for the two report cards (health plan and hospital) are well established and include an audit mechanism. In July of 2013, the Hospital Report Card will become the responsibility of the Vermont Department of Health. New data share agreements between VDH and DVHA may be needed to ensure that the Exchange can post Hospital Report Card data.

The Exchange may have opportunities to create additional measures using data from the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES), the state's all-payer database. Assuming participation in the Blueprint expands, there may also be an opportunity to use the Blueprint's clinical registry for quality measure reporting. These options, however, would be best considered for the future, when the state transitions to its single payer model.

> **Recommendation – Data Collection:** The Exchange should work directly with DFR and VDH to use the existing data processes to acquire the necessary data. All data share agreements should ensure that the Exchange, within DVHA, may use the data.

4.4 Benchmarking

Comparing data from QHPs to benchmarks will supply a broader context to both consumers and regulators, as they evaluate health care providers. The most common method is to use national benchmarks, such those collected and distributed by NCQA's Quality Compass service or AHRQ's CAHPS Benchmarking Database. These benchmarks use percentiles of all health plans in the US, broken out by plan type (commercial, Medicaid, and so forth). The key advantage of this method is that most consumers can easily understand the comparison. National benchmarking will likely prove more useful for public reporting and consumer education than for determining payment incentives, since Vermont plans and providers already operate at a high level of quality.

As mentioned in the *Quality Rating System Report*, we are aware that some Vermont policymakers wish to pursue a system of reporting and benchmarking based on the state's 13 health service areas (HSAs). We acknowledge the potential appeal of service area reporting and benchmarking in achieving the critical goal of reducing regional disparities in quality of care, especially those disparities between the most rural parts of the state and the more populated areas. However, as discussed previously, service area reporting and benchmarking creates methodological challenges around the issues of statistical validity and small numbers when dividing member data into very small HSA cohorts which may vary widely depending on population size. The potential for small numbers quickly becomes acute when a plan attempts reporting by HSA on measures that already have low numbers such as Follow-up After Hospitalization for Mental Illness.

Recommendation – National Benchmarks: We recommend that the Exchange present both national and New England percentile benchmarks, where available, on the Exchange website. This will apply only to measure sets used nationwide, such as HEDIS and CAHPS. Vermont should only use percentiles from the top half of the national distribution, specifically the 50th, 75th, and 90th percentiles. Since Vermont's quality of health care is already high, the minimum expectation of consumers would be that scores are at or above the 50th percentile (i.e., the national average). Scores at or above the 75th percentile (but below the 90th) could be considered "good," and scores at or above the 90th percentile labeled "excellent" or "superior" performance.

Recommendation – Service Area Benchmarks: Vermont should proceed with all due caution before considering reporting performance measures by HSAs . Benchmarks do not currently exist for HSAs. National and regional percentage benchmarks for HEDIS measures are only available for entire health plans. Several years of data would be necessary before data for creating HSA-based benchmarks could be considered. Even now the numbers for some measures are too small to produce meaningful data and rates at an insurer level. Parsing data into even smaller cohorts to create benchmarks may prove unproductive. Analysts should extensively test the existing data to ensure that comparisons are statistically valid. In addition, we recommend that the state carefully consult with the provider community to determine the validity and usefulness of HSA benchmarks. The possibility of public reporting of provider-level measures data should also be carefully considered in conjunction with DFR, The Green Mountain Care Board and the Vermont Medical Society.

4.5 Creating summary ratings

The *Quality Rating System Report* discussed issues raised in the literature on the creation of summary ratings based on composites of a set of individual measure scores. While summary ratings are in some ways problematic, they can still convey useful information to consumers. More importantly, the upcoming federal guidance on QHP rating systems will almost certainly direct states to use summary ratings. There are several systems for creating composite scores in wide use, including:

- NCQA Health Insurance Plan Rankings and Report Cards
- CMS Medicare Star Quality Ratings (for Medicare Advantage plans)
- CMS Hospital Quality Incentive Demonstration scores (for hospitals)
- CMS Nursing Home Compare (for nursing facilities)

Ideally, Vermont should create a rating system that draws the best (and most Vermont-applicable) aspects of each of the above systems. This decision must await the release of federal guidance on the QHP rating system however.

Recommendation – Summary Rating System Design: We recommend that Vermont wait for the expected federal guidance before making any decisions about the methodology it will use to construct summary ratings. CMS has indicated that the minimum requirements for a rating system will use only "generally available and collected metrics and measures" until 2016, so designing the initial summary ratings should not present any challenges. We do anticipate that Vermont will have discretion to customize its summary rating methodology going forward. Once the federal guidance is released, all Vermont stakeholders (the Exchange, other state agencies, providers, and consumers) should collaborate in designing a rating system that best reflects Vermont's priorities.

4.6 Displaying results – lessons from reporting to consumers

Our report, *Best Practices in Publically Reporting Quality Information to Consumers (Reporting to Consumers)* offers several suggestions for maximizing the utility of quality and wellness information for consumers. We repeat them below: Following principles developed over the past 15 years, the presentation of material should:

Group

1. Group data into larger categories, e.g. "patient experience," "effectiveness," and "safety." If a large number of measures are to be presented, additional groupings such as "Staying Healthy," "Getting Better," and "Living with Illness" resonate with consumers.
2. Where possible rank order from best to worse.

Use Visual Cues

3. Use visual "best value" cues, such as a checkmark, help consumers sort through data from multiple domains.
4. Avoid the use of bar graphs unless interpreted for consumers or presented as supplemental information.
5. Embrace a principle of parsimony and consider including plenty of white space to make the presentation less dense for viewing.
6. Avoid the use of dollar signs for the summary of cost data, as consumers can easily misunderstand these signs.

Interpret

7. Interpret the numeric data, especially clinical process measures, with symbols (e.g. stars) or words (best, average, worse).
8. Explain in plain language what goes into a score and offer a technical appendix for consumers who wish to dig deeper.

Content

9. Consider moving, over time, to the presentation of provider specific data (e.g. for hospitals) since consumers want information about their own providers.

10. Provide a glossary of terms

    Recommendation: Use best practices in consumer reporting to design the look of the web-page with quality information.

5. Conclusion

The implementation of the quality requirements for Vermont's Health Benefits Exchange includes incorporating quality into the certification process, monitoring QHP quality activities and incentives tied to quality, and designing a consumer interface that assists consumers deciding between competing health plans. Building upon and leveraging existing Vermont quality activities facilitates the Exchange's implementation task.

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Appendix 1: Contract Language for the Quality Implementation Report

Deliverable 3. Plan for incorporating quality programs into the Exchange, including coordination with existing quality programs outside of the Exchange.

The implementation plan shall include:

- Options and mechanisms for incorporating existing Vermont quality programs into the Exchange to meet federal and State requirements to provide health care quality, outcome and enrollee satisfaction information for the purpose of certifying QHPs and rating QHP quality,
- Identification of gaps between existing Vermont quality programs and federal requirements, with high-level recommendations for filling those gaps,
- Identification of where existing Vermont quality programs exceed federal requirements,
- Identification of quality components that the Exchange should use to rate and potentially certify QHPs,
- Once a quality rating system has been developed, identification of gaps in Vermont's existing infrastructure for data collection, quality measurement, and reporting, including gaps in information technology (IT) capacity to accept quality data and generate web-based reports,
- Recommendations on how to close those gaps developed cooperatively with Vermont IT leads, including recommended procedures for processing data, implementing the scoring process and coordinating Exchange quality programs with Exchange IT development, and
- Identification of potential implementation challenges.