

Recommendations for Covered California Quality Rating System: Fall 2015 Reporting

12/09/2014

Recommendations

1. Report the same 10 CAHPS measures being reported in the existing Covered California QRS (Appendix, Table 3) using the QHP Enrollee Survey (“Beta Test”) results
2. Expand from a 4-star rating to a 5-star rating system
3. Use 25th, 50th, 75th, and 90th percentiles to create the 5 performance categories*
4. Report ratings at the product type level (HMO, PPO, EPO)
5. Use an aggregated all-product type benchmark from CMS -- combining HMO, PPO, EPO, results
6. Blend the national and HHS western region results, 50/50, to create the benchmark
7. Report only the global rating in the health plan compare summary information as is done currently. Consider reporting the 3 domain ratings (Access, Plan Service, Doctors & Care) as supplemental information
8. Do not report clinical effectiveness measures (HEDIS)

*the 5 performance categories are not a relative distribution of QHPs such that the top 10% of plans are rated 5-star; rather, the proposed method would result in very few 5-star plans as it means the top rated plans are consistently achieving “5 star results” across all domains

Rationale

1. The proposed method changes are consistent with the CMS proposed QRS that will be reported for all QHPs beginning Fall 2016.
2. Covered California can use the Fall 2015 reporting as a transition toward the national QRS, helping, to avoid a potentially jarring shift to a national benchmark in Fall 2016 by using a blended national/regional benchmark next year.
3. This approach can be implemented by CalHEERS with modest additional effort – to expand the display to 5 stars and to expand the QRS health plan listing to report results at QHP product type level (HMO, EPO, PPO) for each Issuer.
4. Using the existing 10 CAHPS measures is consistent with CAHPS information that is widely reported, nationwide, today. There are 3 additional domains in the QHP Enrollee Survey (access to information, care coordination and cultural competency) but none of these are standard CAHPS reporting topics as the questions largely are drawn from supplemental CAHPS surveys. The Access to Information questions and measure are used in certain surveys like the NCQA HEDIS CAHPS Survey but the measure is not used in health plan performance ratings. The care coordination and cultural competence measures are not NQF endorsed as this is the first time that certain questions are grouped to compose these two proposed measures.
5. The composition of the 3 domains that are constructed, but not publicly reported, in the existing Covered California QRS will change when CMS reports the Fall 2016 results (Table 2). Reporting of these domain-level scores in Fall 2015 should be done as supplemental information (not directly adjacent to or nested in the global QRS rating) given the make-up of these topics will change in the next year and Covered California will need to revamp its QRS consumer presentation in 2016 to communicate results across a much larger set of clinical and member experience measures.

6. The reporting of any or all of the clinical effectiveness measures in Fall 2015 has a number of drawbacks:

- Of the 19 clinical effectiveness measures that QHPs will report to CMS in 2015, fewer than half can be scored using the standard HEDIS specifications due to QRS start-up year measurement constraints including missing data for lookback periods, continuous enrollment rules for members enrolling after January 1, and QHP uncertainties about using the hybrid method for several measures given beta test/start-up status.
- The clinical effectiveness measures sampling and scoring methodology isn't complete – CMS is using the beta test to finalize aspects of these methods and possibly revise the measures set contingent on the beta test results. California could not implement the clinical effectiveness measures for the Fall 2015 open enrollment unless we decided to create a customized scoring methodology; a method that would be replaced within the year by the federal QRS. Moreover, CMS' QRS methods cannot be fully completed until Fall 2016 given that 14 of the clinical effectiveness measures will not be collected or scored during the beta test because they require a longer lookback period than 12 months.
- It is likely that a number of QHPs will not have reportable results for various clinical measures given smaller enrollments. As such, the Fall 2015 clinical effectiveness reporting would be complicated by unevenness in the reportable measures. There are methods techniques to adjust for QHP differences in the mix of reportable measures but large differences in the measures mix would be a concern – the smaller QHPs could be disadvantaged by having “not reportable” results for certain topics (e.g., diabetes and mental health). Seven of the California Exchange plans have small 2014 enrollment (four plans account for >90% of total enrollment).
- It would be difficult to produce the results for the Fall open enrollment. Covered California should assume that it would have no guidance from CMS about its beta test results until late summer or early Fall 2015 at best. Given that the beta test is the first Exchange reporting and scoring cycle it's likely that the beta test results may be delayed even later into the fourth quarter. And, the addition of some number of clinical effectiveness measures likely would require a new CalHEERs display which amplifies the short timeline concern (the results could be reported as supplemental information in a pdf but that heightens the concern about the cost/effort versus the value). We can mitigate this timing uncertainty for the QHP Enrollee Survey results because we have an established scoring approach and setup in CalHEERs; the methods work is more modest and centers on getting benchmark data from CMS and revising the scoring formula per the new benchmark data.

Covered California and the QHPs should make plans to jointly evaluate the clinical effectiveness results in late 2015 to assess performance improvement needs, implications for the QHP performance standards and to communicate with all stakeholders about the Exchange-wide results.

Appendix: Quality Rating System Measures

Table 1. QRS Candidate Measures 2014-2016

Measures	Covered California QRS Fall 2014	Covered California Proposed QRS Fall 2015	CMS QRS Beta Test 2015	CMS QRS* Fall 2016
Enrollee Survey	<p>Access Getting Needed Care Getting Care Quickly</p> <p>Doctors & Care Rating Health Care Rating Personal Doctor Rating Specialist</p> <p>Plan Service Rating Health Plan Customer Service</p>	<p>Access Getting Needed Care Getting Care Quickly</p> <p>Doctors & Care Rating Health Care Rating Personal Doctor Rating Specialist</p> <p>Plan Service Rating Health Plan Customer Service</p>	<p>Access Getting Needed Care Getting Care Quickly</p> <ul style="list-style-type: none"> • Get Care After Hours <p>Doctors & Care Rating Health Care Rating Personal Doctor Rating Specialist</p> <p>Plan Service Rating Health Plan Customer Service</p> <ul style="list-style-type: none"> • Wait Time to Talk Customer Service • Form Easy to Fill Out • Explain Purpose of Form <p>Care Coordination</p> <p>Cultural Competence</p> <p>Access to Information</p>	<p>Access Getting Needed Care Getting Care Quickly</p> <ul style="list-style-type: none"> • Get Care After Hours <p>Doctors & Care Rating Health Care Rating Personal Doctor Rating Specialist</p> <p>Plan Service Rating Health Plan Customer Service</p> <ul style="list-style-type: none"> • Wait Time to Talk Customer Service • Form Easy to Fill Out • Explain Purpose of Form <p>Care Coordination</p> <p>Cultural Competence</p> <p>Access to Information</p>
Clinical Effectiveness	Not Applicable	Not Applicable	<p>19 Measures</p> <ul style="list-style-type: none"> • 18 Clinical Measures • Adult Flu Shots (C) 	<p>33 Measures</p> <ul style="list-style-type: none"> • 30 Clinical Measures • Adult Flu Shots (C) • Tobacco Cessation (C) • Aspirin Use (C)

*Final enrollee survey measures contingent on beta test results; (C) = CAHPS enrollee survey measures

Table 2. QRS: CMS Proposed Hierarchy of QHP Enrollee Survey Questions and Measures

QRS Summary Indicator	QRS Domains	QRS Composites/Measures	Number of Questions
Enrollee Experience	Access to Care	Access to Care	5
	Care Coordination	Care Coordination	6
	Doctors & Care	Rating of All Health Care	1
		Rating of Personal Doctor	1
		Rating of Specialist	1
	Cultural Competency	3	
Plan Efficiency, Affordability & Management	Plan Service	Access to Information	3
		Plan Administration	5
	Efficient Care	Rating of Health Plan	1
		NO CAHPS MEMBER EXPERIENCE TOPICS	
Clinical Quality Management	NO CAHPS MEMBER EXPERIENCE TOPICS		

Table 3. CAHPS Measures Used in Covered California QRS

<p>Access to Care Domain</p> <p><u>Getting Needed Care Composite</u></p> <ul style="list-style-type: none">● In the last 12 months, how often was it easy to get appointments with specialists?● In the last 12 months, how often was it easy to get the care, tests, or treatment you thought you needed through your health plan? <p><u>Getting Care Quickly Composite</u></p> <ul style="list-style-type: none">● In the last 12 months, when you needed care right away, how often did you get care as soon as you thought you needed?● In the last 12 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor’s office or clinic as soon as you thought you needed?
<p>Doctors and Care Domain</p> <p><u>Rating of Health Care:</u> Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 12 months?</p> <p><u>Rating of Personal Doctor:</u> Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?</p> <p><u>Rating of Specialist Seen Most Often:</u> We want to know your rating of the specialist you saw most often in the last 12 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?</p>
<p>Plan Service Domain</p> <p><u>Rating of Health Plan:</u> Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?</p> <p><u>Customer Service Composite</u></p> <ul style="list-style-type: none">● In the last 12 months, how often did your health plan’s customer service give you the information or help you needed?● In the last 12 months, how often did your health plan’s customer service staff treat you with courtesy and respect?