The New York State Health Benefit Exchange:
Developing a Quality and Satisfaction Ratings Proposal

Background

The New York State Department of Health (DOH) has been collecting analyzing and publicly reporting health plan performance since 1994. Plan performance is evaluated annually across a broad range of nationally recognized quality, utilization and member satisfaction metrics. The data generated from this reporting system, known as the Quality Assurance Reporting Requirements (QARR), are used for a number of different purposes including: providing financial rewards for high quality plans, determining auto-assignment preference, considering health plan expansion requests, measuring continuous quality improvement, and for informing legislators, policy makers and consumers. The QARR data is collected for a variety of plan products including commercial, Medicaid, Child Health Plus and preferred provider organization (PPO).

There are two primary components to the QARR dataset; the access, quality and utilization measures, largely adopted the National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) and the consumer experience of care survey questions from the Consumer Assessment of Health Care Providers and Systems (CAHPS) survey. There are approximately 60 HEDIS measures and an additional 20 rating and composite CAHPS measures. While QARR data is collected annually NCQA does rotate some of their measures in order to allow for improvement cycles to run their course and to reduce the reporting burden on plans. CAHPS data is generally collected annually for commercial insurers and on a biennial basis for Medicaid plans, however under the Affordable Care Act (ACA) CAHPS for Medicaid plans will become an annual endeavor beginning in 2014. A small number of New York State-specific measures are added to both the quality and satisfaction measures to address areas of particular concern to the state (e.g. quality of adolescent preventive care).

The highly experienced team assigned to collect and analyze the QARR data includes clinicians, analysts and program evaluators. Public reporting of QARR data has gone from being a 12 month process to one that is now complete in approximately five months, with the earliest release of results within three months of data submission. After data is validated and processed, staff begin the work of sharing with all interested parties, including publicly and commercially insured individuals who can use the information produced to inform their health pan choices. QARR data is posted on the Department's website in several formats including eQARR, (an electronic point and click too) and the annual report on Managed Care Performance. In addition, Consumer Guides, that distill results from many measures into a highly readable format, are made available in hard copy to all new Medicaid recipients. Electronic versions are available on the DOH website for commercially insured.

Proposal

Under provisions of the ACA, Section 1311 requires to establish Health Benefit Exchanges where people, who do not have employer-based health insurance or earn too much for publicly supported health insurance, can purchase health insurance for themselves and their families. States will determine which plans are eligible to participate in the exchanges and these Qualified Health Plans (QHPs) will be eligible to enroll members on July 1, 2013. New York's Health Benefit Exchange will be fully operational in January 2014. As required by Section 1311(e) (3), exchanges will provide standardized data reporting on the Qualified Health plans which describes their premium and co-pay costs, provider network composition and quality and satisfaction information. Initially the States will have the ability to determine what information they will post on the on their Health Benefit Exchange sites with federal requirements for reporting expected to begin in 2016.

Given the DOH's long history in collecting, analyzing and reporting quality and satisfaction data and information the Office of Quality and Patient Safety proposes to lead an assessment of how quality

reporting for the Qualified Health Plans should be assembled and shared as part of the Health Benefit Exchange. In conjunction with colleagues in the DOH's Division of Coverage and Enrollment and the Department of Financial Services, we envision an information gathering process that involves both consumers and stakeholders, conducted over the summer and fall of 2012 which results in a short term plan for quality and satisfaction reporting in the Exchange prior to federal reporting requirements starting in 2016. Information from current report cards, such as NCQA's Health Plan Report Card and quality measures in Health Plan Accreditation will be incorporated as much as possible to align as much as possible with potential future guidance from CMS.

The proposed activity timeline is outlined in the table below:

Activity	**Timeline**
Assemble a project team and develop project timeline.	June 2012
Develop proposed methodology and measures for quality rating system	August 2012
Develop templates, mock-ups of web pages to share with interested parties. (consumers, stakeholders)	August 2012
Stakeholder input (health plans, consumer advocacy groups, others)	October 2012
Develop final set of QHP quality rating recommendations for Executive review and approval.	December 2012
Produce initial data for QHP quality rating for inclusion in Health Benefit Exchange with 2012 data and format for inclusion in consumer portal.	June 2013
Quality data incorporated into consumer portal for use in plan selection	December 2013 (Ready for Exchange opening in January 2014)

Quality Rating Methodology and Measures:

The Office of Quality and Patient Safety will develop a quality rating system which contains five domains contributing to an overall rating for each organization/product (product refers to type of health insurance such as HMO, and PPO) . The five domains are satisfaction, children's health, pregnancy care, adult health and health conditions. Quality information for the specific health benefit exchange population will begin in 2016.

Prior to 2016, OQPS will use the quality data which is required to be reported annually to determine ratings. OQPS will use plan results by product for each organization. For example, OQPS will use CHP results for CHP plans, Medicaid results for Medicaid HMOs and PHSPs, Commercial HMO results for Commercial HMO plans and commercial PPO results for commercial PPOs. Organizations that are offering a product in the exchange for which they do not currently report data, results for another product will be used; the results will include a notation that the results represent another product. For example, a plan is offering a PPO product in the exchange and currently reports commercial HMO and Medicaid results would have the commercial HMO results in the PPO offering with a notation. Medicaid plans offering commercial products in the exchange will have their Medicaid results used with a notation and vice versa for a commercial plan offering Medicaid in the exchange. Organizations participating in the NY Health Benefit Exchange that do not report QARR will have an indication of 'Data not available' for the quality section. Organizations with quality data for members outside of New York State will not be able to use the out-of-state results in the exchange for New York.

The structure of the quality information will be through three layers: 1) overall performance for an organization/product; 2) organization/product performance for five domains; and 3) organization/product results with statewide significance level for the quality measures in the domains. Varying levels of information allows the consumer to access the desired amount of detail for information about quality performance. The structure employing overall performance with an ability to link to more detail is used by NCQA in their health plan accreditation reports.

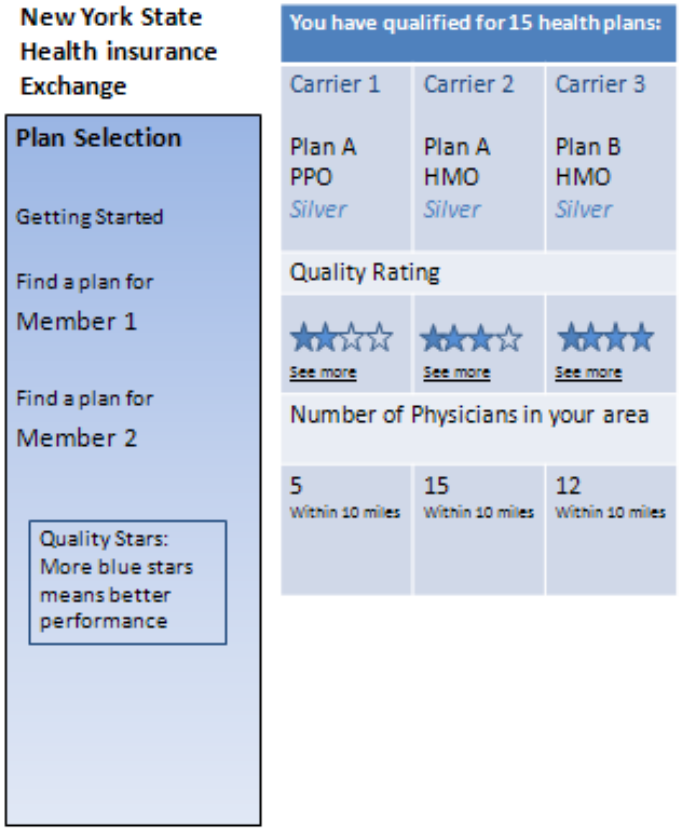
Level 1 – Overall Performance

Level 1 is the highest level of aggregation and will be a single result for the overall performance. The overall performance of the organization for each product will be determined from the number of points achieved in each domain.

Number of points from Domains	Overall Performance (Based on 4 Stars)
0 to 3 points	
4 to 7 points	
8 to 11 points	
12 to 15 points	

Level 1 information would be displayed in the portal when the quality section appears. The consumer would see the information under quality without needing to select any further requests. If the consumer wanted more quality information details, the consumer would select 'See more' to receive the next level of quality data.

Level 1 Quality information



Level 2 – Performance for Domains

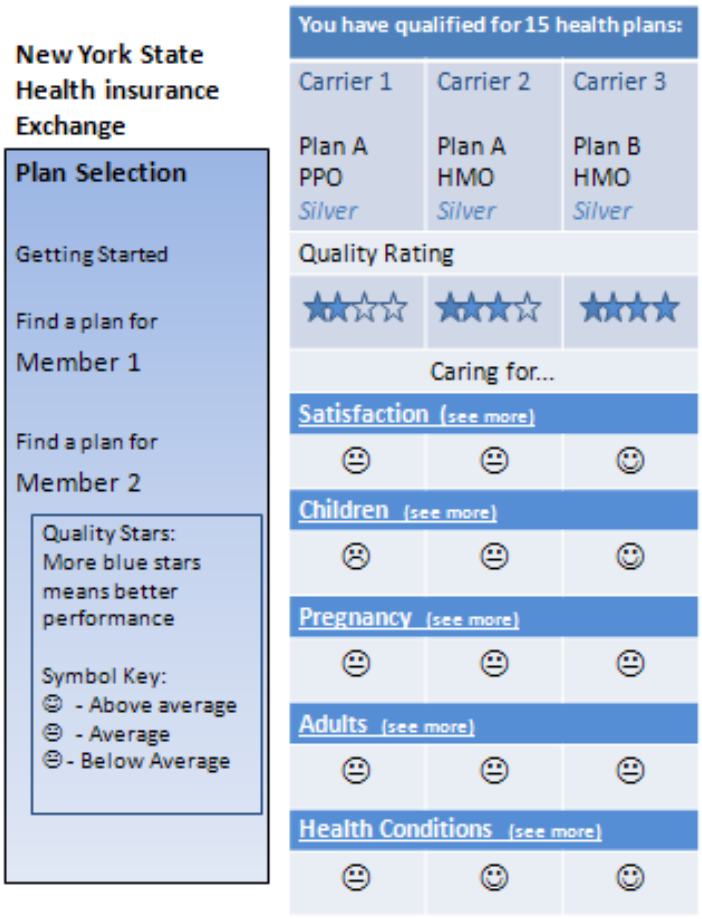
If the consumer wanted more quality information details, the consumer would select 'See more' to receive the next level of quality data. Consumers that wish to see how plans performed in the domains that lead to the overall performance could click a link that will cause additional rows to appear.

The domains represent the quality of care for a group of measures relevant to a population or condition. Using domains to reflect performance in a general area is similar to the NCQA Health Plan Report Card layout and uses a simplified display of information to provide a further level of detail. Hovering over the symbol would display the terms 'Below Average', 'Average', and 'Above Average'.

Domain Performance	Symbol	Points for Overall Score
Below Average	☹	0 points
Average	😐	1.5 points
Above Average	☺	3 points

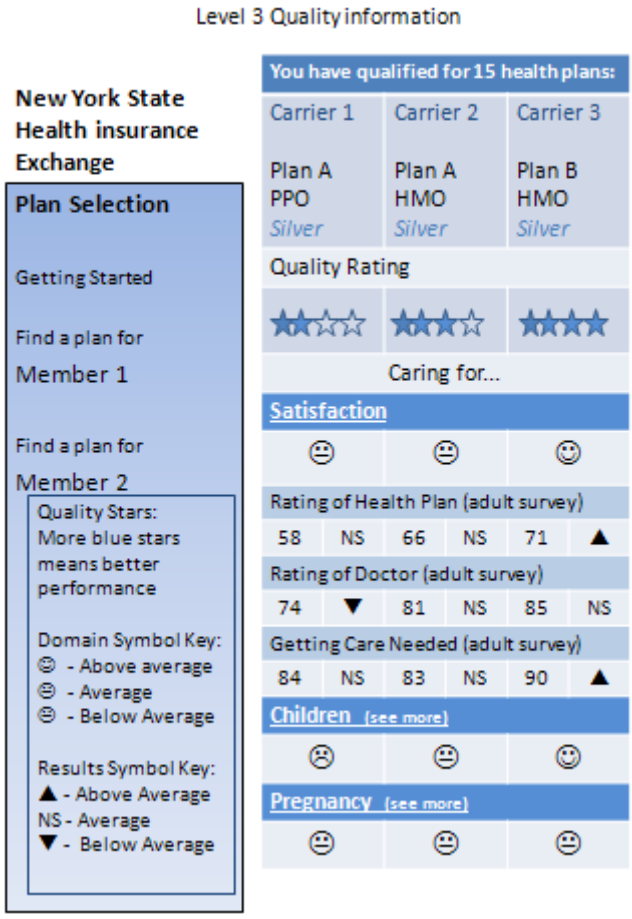
Points for each domain are summed for all domains and total points are rounded to the nearest whole number. The number of points then determines the number of stars in the overall performance.

Level 2 Quality information



Level 3 – Plan Performance by Measures

Consumers who wish to see plan performance for the individual quality measures in a domain could select the link to see more and again, additional rows would appear. In this level, the organization/product result would be displayed as the plan percentage and the level of significance in the difference to the statewide average for the product.



Methodology and Measures in Domain Performance –

Plan scoring for multiple measures is determined by using a standard score or z-score. The z-score is a calculation that describes the relationship of the plan's rate to the statewide average taking into account the standard deviation of the rate. If a z-score exceeds a threshold, it is capped to prevent a single measure from impacting overall rates excessively. Then a domain's composite score is calculated by averaging the z-scores for all of the measures.

Ratings for the domains are assigned based on whether the composite z-score is above or below the 95 percent confidence limit. Composite z-scores that are less than -1.96 are 'below average', those greater than 1.96 are 'above average' and those between -1.96 and 1.96 are 'average'.

The formula used to create the z-score for the guides is as follows:

$$\text{Standard deviation} = \sqrt{\frac{(\text{measure specific rate}/\ 100)*(1-(\text{measure specific rate}/\ 100))}{\text{denominator}}}$$

$$\text{Z-Score} = \frac{(\text{measure specific rate}/\ 100) - (\text{statewide rate}/\ 100)}{\text{standard deviation}}$$

Determining Domains and Measures-

Five domains will be used in the Health Benefit Exchange to provide information about quality in large sectors of care, while still allowing the consumer to see results within the page. The domains represent large segments of populations which may be of interest to consumers. The domains are: Caring for…Satisfaction, Children, Pregnancy, Adults, and Health conditions.

For consumers targeting Child Health Plus plans, overall performance would be limited to two domains. Measures in the domains were selected using measures currently used in NYS's Regional Consumer Guides for Health Plans. We also reviewed information about the measures included in NCQA's Health Plan Accreditation sets for each product. All measures selected in the domains are included in the Health Plan Accreditations sets for 2011, with the exception of Colorectal Cancer screening for Medicaid. Use of measures in the accreditation set will facilitate transition of ratings in 2016.

Proposed Measures for Quality Rating Scores (2014-2015)

Satisfaction

Commercial PPO	Commercial HMO	Medicaid	Child Health Plus
(Adult survey results) • Rating of Health Plan • Rating of Doctor • Getting Care Needed	(Adult survey results0 • Rating of Health Plan • Rating of Doctor • Getting Care Needed	(Adult survey results) • Rating of Health Plan • Rating of Doctor • Getting Care Needed	(Child survey results) • Rating of Health Plan • Rating of Doctor • Getting Care Needed

Children

Commercial PPO	Commercial HMO	Medicaid	Child Health Plus
• Immunization (combo 3) • Weight Assessment -BMI • Appropriate Treatment for URI • Appropriate Testing for Pharyngitis	• Immunization (combo 3) • Weight Assessment -BMI • Appropriate Treatment for URI • Appropriate Testing for Pharyngitis	• Immunization (combo 3) • Weight Assessment -BMI • Appropriate Treatment for URI • Appropriate Testing for Pharyngitis	• Immunization (combo 3) • Weight Assessment -BMI • Appropriate Treatment for URI • Appropriate Testing for Pharyngitis

Pregnancy

Commercial PPO	Commercial HMO	Medicaid
• Timeliness of Prenatal Care • Postpartum Care	• Timeliness of Prenatal Care • Postpartum Care	• Timeliness of Prenatal Care • Postpartum Care

Adults

Commercial PPO	Commercial HMO	Medicaid
• Breast Cancer Screening • Cervical Cancer Screening • Colorectal Screening • Flu Shot	• Breast Cancer Screening • Cervical Cancer Screening • Colorectal Screening • Flu Shot	• Breast Cancer Screening • Cervical Cancer Screening • Colorectal Screening • Flu Shot

Health Conditions

Commercial PPO	Commercial HMO	Medicaid
• Advising Smokers to Quit • Cholesterol Management – LDL-C below 100 • Controlling High Blood Pressure • Diabetes Care Eye Exam • Spirometry Testing for COPD • Use of Appropriate Asthma Medications • Follow Up After Hospitalization for Mental Illness within 7 Days	• Advising Smokers to Quit • Cholesterol Management – LDL-C below 100 • Controlling High Blood Pressure • Diabetes Care Eye Exam • Spirometry Testing for COPD • Use of Appropriate Asthma Medications • Follow Up After Hospitalization for Mental Illness within 7 Days	• Advising Smokers to Quit • Cholesterol Management – LDL-C below 100 • Controlling High Blood Pressure • Diabetes Care Eye Exam • Spirometry Testing for COPD • Use of Appropriate Asthma Medications • Follow Up After Hospitalization for Mental Illness within 7 Days