



## Recommendations for Health Insurance Exchange Quality Measure Requirements

Affordable Care Act provisions require quality measurement for plans offered by health insurance Exchanges. Below we summarize these requirements and NCQA’s recommendations. Legislative requirements include the following.

- Health plans to provide information to enrollees and prospective enrollees, and to each Exchange in which the plan is offered, on quality measures for health plan performance
- Exchange to report to the Secretary, at least annually, Initial Core Set of Children’s Health Care Quality Measures (core set required under CHIPRA legislation)
- Exchanges to rate qualified health plans offered through an Exchange in each benefit level on the basis of the relative quality and price
- Exchanges to evaluate the level of enrollee satisfaction with qualified health plans offered through an Exchange
- Plans offered through Exchanges must be accredited with respect to local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set, patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems survey, as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs”

### **Recommendation: A National Core Set of Quality Measures**

*Issue: Measurement across the country and populations with standardized measures supports focused quality improvement and benchmarking.*

- Federal regulations should require a core set of quality measures for all Exchanges to use to evaluate plans and for consumer reporting. A standardized set of quality measures allows for aligned quality improvement and comparison at national and state levels. A national set will require fewer resources for measurement alone, especially in plans operating in multiple states.
  - Required quality measures should align with federal, state and private quality reporting requirements
  - Measures used in all federal programs and across populations need to be carefully developed, tightly specified and supported by consumers, purchasers and professionals. Tight specifications increase the ability to make plan to plan comparisons. NCQA’s HEDIS® and other measures endorsed by the National Quality Forum meet these criteria.
- Use the same measures, or a subset, for the national set of quality measures for the health plan rating methodology. Using the same measures for multiple purposes reduces data collection and reporting efforts.
- Start with a smaller set of measures and then increase this over time. The measures included in the starter set should meet the following criteria.
  - In use under public and privately sponsored health care coverage arrangements
  - Specified for health plans
  - Relevant and prevalent to the Exchange population
  - Balanced between measures that can be reported using only administrative data and measures that may require medical record review – measures assessing health outcomes usually require medical record review
  - Align with the National Quality Strategy health improvement goals
    - Safer care

- Effective care coordination
- Person and family centered care
- Prevention and treatment of leading causes of mortality
- Supporting better health in communities
- Making care more affordable
- Included in one or several federal quality measure initiatives
  - Initial Core Set of Children’s Health Care Quality Measures
  - Proposed Quality Measures for Medicaid-Eligible Adults (core set required under ACA)
  - Meaningful Use – clinical quality measures.

The appendix presents specific recommendations for measures to include in the set of Exchange quality measures for the first two years of measurement.

**Recommendation: Consistent Data Collection of Quality Measures**

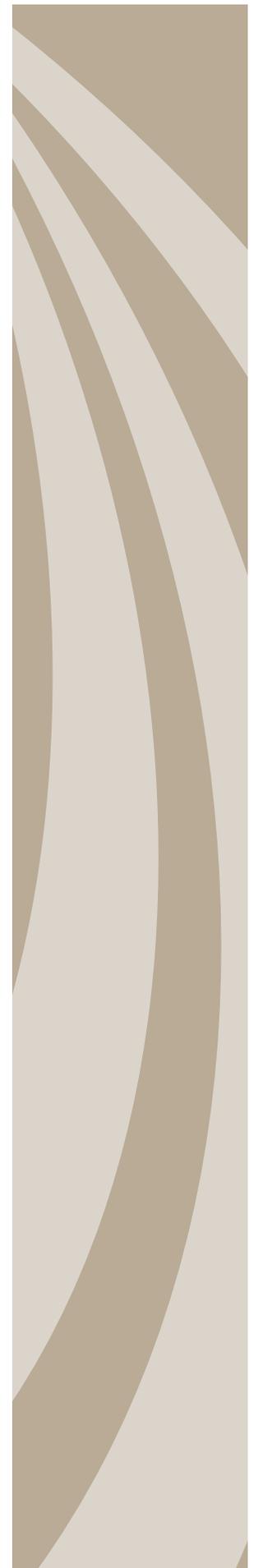
*Issue: Consistent data collection methodologies are necessary for comparison, in addition to standardized measures.*

- Require the same quality measures, collected using the same methodology, for all types of health plans- HMOs and PPOs. Medicare, employers and many states currently hold HMOs and PPOs to the same measurement standards to allow comparison across plan types. For consumers, the difference between plan types is difficult to understand and the distinctions are often based on narrow legal distinctions.
- Require collection and reporting of quality measures at the qualified plan level, not the benefit package level. The plan level, or contract or qualified health plan, is the entity that issues a contract for insurance for the Exchange populations. To validly measure quality of care, a sufficient sample or population size is needed. Measurement at the plan level, as opposed to the benefit packages or products level provides the best possibility of a sufficient sample size. Also, benefit level reporting can be resource intensive for plans.
- Allow quality measure reporting across state lines in large metropolitan areas, for example Maryland, Virginia and the District of Columbia.
- Require annual data collection of quality measures – beginning in June 2015 on 2014 Exchange enrollees. Health plans currently report quality measures, such as HEDIS, annually. The annual data collection period also allows time for health plans to enroll members and provide services.
- Require independent auditing of measure results to ensure comparability of results. Auditing provides an important feedback loop for plans, especially in the early years of reporting.

**Recommendation: Allow Health Plans to Combine Exchange Populations with Medicaid or Commercial Populations**

*Issue: Particularly in the early years relatively small enrollment in Exchange plans will affect the ability of plans to report quality measures. Some approaches can mitigate this.*

- Encourage health plans to collect and report quality measures on a population that includes their Exchange members combined with their Medicaid or commercial members. Individuals covered by Exchanges and Medicaid or Commercial coverage are likely to have sufficiently similar demographics to allow for combination. In some states, relatively few people may enroll in the Exchange program initially, so combining Exchange and Medicaid populations will provide a more measurable picture of care. Also, combining Exchange and other populations will reduce the problem of loss of enrollees for measurement due to enrollees “churning” between Exchange and Medicaid coverage and encourages accountability across populations.



	Exchange Population Only	Combine Exchange with Medicaid or Commercial Populations
Pros	<ul style="list-style-type: none"> <li>Understand and track the quality of care provided to the Exchange population.</li> <li>Level playing field for Medicaid and Commercial health plans</li> <li>Promote consistency across the nation – some states have no Medicaid managed care</li> </ul>	<ul style="list-style-type: none"> <li>Population size more likely to give reportable results of more measures.</li> <li>Captures members who “churn” from Medicaid to Exchanges coverage and aligns with policy goals for seamless Medicaid and Exchange policies</li> </ul>
Cons	<ul style="list-style-type: none"> <li>With a small population size, results possible for only the most prevalent conditions.</li> </ul>	<ul style="list-style-type: none"> <li>Cannot understand and track the quality of care provided to the Exchange population</li> <li>Combined Medicaid and Exchange populations will most likely have lower results than a combined Commercial and Exchange population</li> </ul>

TABLE 1

- The table above shows the pros and cons for measuring the Exchange population only or combining populations.
- In the initial years, allow health plans to collect and report quality data based on multiple years to achieve a sufficient sample size.
- Reevaluate combining populations based on actual enrollment experience.
- As the numbers of enrollees in Exchanges continue to grow and we understand how many health plans are participating in Exchanges, consider moving to separate Exchange reporting.

**Recommendation: Use CAHPS<sup>®1</sup> as the Enrollee Satisfaction Survey**

*Issue: Use of a standardized patient experience survey is desirable and feasible.*

- Use the CAHPS patient experience survey as the enrollee satisfaction system for Exchanges. CAHPS is maintained by the Agency for Healthcare Quality and Research. It is widely used by plans with their commercial, Medicaid and Medicare populations.
- Require plans to report CAHPS results based on a sample of Exchange enrollees only. Insufficient population size should not be a significant issue for such a survey.
- Consistent with the growing emphasis on health disparities, the federal government should support translation of CAHPS into languages other than English and Spanish.

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<sup>1</sup> CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Table 2 presents recommendations for the starter set of Exchange quality measures to be included in the first two years of measurement. Here is the methodology for developing the measure set.

- Measures in the Initial Core Set of Children’s Health Care Quality Measures (core set required under CHIPRA legislation) are not included, since the legislation specifically requires them to be reported by Exchanges.
- Measures with specifications that require only one year for proper measurement are recommended for 2015 reporting covering 2014 enrollees. Measures that require more than a year are recommended for 2016 reporting covering 2015 enrollees.
- Measures included
  - All measures in the Proposed Quality Measures for Medicaid-Eligible Adults
  - Adult BMI Assessment because it closely aligns with National Quality Strategy (#4 Prevention and Treatment of Leading Causes of Mortality)
  - Plan All-Cause Readmissions because it closely aligns with National Quality Strategy (#3 Effective Care Coordination)
- Measures excluded
  - Measures not currently in use (not being collected and reported by public or private programs)
  - Measures not specified for health plans
  - Measures for conditions not prevalent in the Exchange population (e.g., schizophrenia in Medicaid populations)
  - Non- HEDIS measures that require medical record review for data collection - to reduce measurement effort during first years of reporting (e.g., transmission of transition record- inpatient discharges to home/self care). Medical record review HEDIS measures are included because plans are already collecting and reporting the measures.

Measure	Steward	Data Collection Methodology	National Prevalence	National Quality Strategy	Proposed Adult Medicaid Set	CHIPRA Core Set	Meaningful Use Measure	NQF Endorsed
<b>Begin Reporting in 2015</b>								
<p><b>1 Ambulatory Care: Outpatient and Emergency Department Visits</b> This measure summarizes utilization of ambulatory care in the following categories.</p> <ul style="list-style-type: none"> <li>• Outpatient Visits</li> <li>• Emergency Department Visits</li> </ul>	NCQA	Administrative	-	#6 Making care affordable	Yes	No	No	No
<p><b>2 Annual Monitoring for Patients on Persistent Medications</b> Percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. For each product line, report each of the four rates separately and as a total rate. Rate 1: Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB) Rate 2: Annual monitoring for members on digoxin Rate 3: Annual monitoring for members on diuretics Rate 4: Annual monitoring for members on anticonvulsants Total rate (the sum of the four numerators divided by the sum of the four denominators)</p>	NCQA	Administrative	700,000 visit an emergency room each year due to an adverse drug event <sup>ii</sup>	#1 Making Care Safer	Yes	Not Applicable to the Population (NA)	No	0021
<p><b>3 CAHPS Health Plan Survey v 4.0 - Adult Questionnaire</b> 30-question care survey of adult health plan members that assesses the quality of care and services they receive. Level of analysis: health plan – HMO, PPO, Medicare, Medicaid, commercial</p>	NCQA	Survey	-	#2 Person- and Family-Centered Care	Yes	NA	NA	0006
<p><b>4 Cervical Cancer Screening</b> The percentage of women 21-64 years of age who had at least one Pap test in the past three years.</p>	NCQA	Hybrid (Medical Record Review and Administrative)	12,280 US women diagnosed, 4,021 died <sup>ii</sup>	#5 Supporting Better Health in Communities	Yes	NA	Yes	0032
<p><b>5 Comprehensive Diabetes Care</b> The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had each of the following: Eye exam (retinal)- LDL-C screening- Hemoglobin A1c (HbA1c) testing- Nephropathy monitoring</p>	NCQA	Hybrid	25.8 million diabetics <sup>ii</sup>	#3 Effective Care Coordination	Yes (LDL-C Screening, HbA1c testing)	NA	Yes	0055-0064
<p><b>6 Controlling High Blood Pressure</b> The percentage of members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled.</p>	NCQA	Hybrid	74.5 million people over the age of 20 with hypertension <sup>iv</sup>	#4 Prevention and Treatment of Leading Causes of Mortality	Yes	NA	Yes	0018

Measure	Steward	Data Collection Methodology	National Prevalence	National Quality Strategy	Proposed Adult Medicaid Set	CHIPRA Core Set	Meaningful Use Measure	NQF Endorsed
7 <b>PQ1 10: Dehydration</b> The number of admissions for dehydration per 100,000 in population.	AHRQ	Administrative	In 2004, 518,000 hospitalizations. <sup>v</sup>	#5 Supporting Better Health in Communities	Yes	NA	No	0280
8 <b>Flu Shots for Adults Ages 50-64</b> Percentage of patients age 50-64 who report having received an influenza vaccination during the past influenza vaccination season	NCQA	Survey (CAHPS)	5-20% contract the flu <sup>vi</sup>	#5 Supporting Better Health in Communities	Yes	NA	No	0039
9 <b>Follow-Up After Hospitalization for Mental Illness</b> The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.	NCQA	Administrative	2.4 million hospital discharges for mental illness (all ages) <sup>viii</sup>	#5 Supporting Better Health in Communities	Yes	Yes	No	0576
10 <b>HIV/AIDS Medical Visit</b> Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with at least one medical visit in each 6 month period with a minimum of 60 days between each visit	NCQA	Hybrid	In 2006, over 1 million people were infected with HIV <sup>viii</sup>	#3 Effective Care Coordination	Yes	No	No	0403
11 <b>Inpatient Utilization: General Hospital/Acute Care</b> This measure summarizes utilization of acute inpatient care and services in the following categories. <ul style="list-style-type: none"> <li>Total inpatient</li> <li>Medicine</li> </ul>	NCQA	Administrative	-	#6 Making care affordable	Yes	No	No	No
12 <b>Medical Assistance with Smoking Cessation</b> The percentage of patients 18 years of age and older who were current smokers or tobacco users, who were seen by a practitioner during the measurement year and who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods or strategies.	NCQA	Survey (CAHPS)	In 2009, 46 million people, or 20.6% of all US adults were smokers. <sup>ix</sup>	#4 Prevention and Treatment of Leading Causes of Mortality	Yes	NA	Yes	0027
13 <b>Mental Health Utilization</b> Number and percentage of members receiving the following mental health services during the measurement year. <ul style="list-style-type: none"> <li>Any service</li> <li>Inpatient</li> <li>Intensive outpatient or partial hospitalization</li> <li>Outpatient or ED</li> </ul>	NCQA	Administrative	-	#6 Making care affordable	Yes	Yes	No	No
14 <b>Proportion of Days Covered (PDC): 5 Rates by Therapeutic Category</b> Percentage of patients 18 years and older who met the proportion of days covered (PDC) threshold of 80% during the measurement year. A performance rate is calculated separately for the following medication categories: Beta-Blockers (BB), Angiotensin-Converting Enzyme Inhibitor/Angiotensin-Receptor Blocker (ACEI/ARB), Calcium-Channel Blockers (CCB), Diabetes Medication, Statins.	PGA	Administrative	9 out of 10 older Americans reported using at least one prescription drug in the past month <sup>x</sup>	#4 Prevention and Treatment of Leading Causes of Mortality	Yes	NA	No	0541

Measure	Steward	Data Collection Methodology	National Prevalence	National Quality Strategy	Proposed Adult Medicaid Set	CHIPRA Core Set	Meaningful Use Measure	NQF Endorsed
<b>Begin Reporting in 2016</b>								
15 Adult BMI Assessment The percentage of members 18-74 years of age who had an outpatient visit and who had their body mass index documented during the measurement year or the year prior to the measurement year.	NCQA	Hybrid	Obesity affects more than 1/3 of the adult population <sup>xi</sup>	#4 Prevention and Treatment of Leading Causes of Mortality	No	No	Yes	No
16 Antidepressant Medication Management The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication.	NCQA	Administrative	1 in 10 people <sup>xii</sup>	#5 Supporting Better Health in Communities	Yes	NA	Yes	0105
17 Breast Cancer Screening The percentage of women 40-69 years of age who had at least one mammogram in the past two years.	NCQA	Administrative	120.4/100,000 women <sup>xiii</sup>	#5 Supporting Better Health in Communities	Yes	NA	Yes	0031
18 Cholesterol Management for Patients With Cardiovascular Disease (LDL-C Screening only) The percentage of members 18-75 years of age who were discharged for acute myocardial infarction, coronary bypass or percutaneous transluminal coronary angioplasty, or who had a diagnosis of IVD and received an LDL-C screening.	NCQA	Hybrid	12% of people over age 18 living with heart disease <sup>xiv</sup>	#4 Prevention and Treatment of Leading Causes of Mortality	Yes	NA	Yes	0075
19 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment Percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following. Initiation of AOD Treatment: The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.	NCQA	Administrative	22.3 million people are substance abusers <sup>xv</sup>	#5 Supporting Better Health in Communities	Yes	No	No	0004
20 Persistence of Beta-Blocker Treatment After a Heart Attack Percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged alive from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for six months after discharge	NCQA	Administrative	7.9 million people over the age of 60 have a heart attack <sup>xvi</sup>	#4 Prevention and Treatment of Leading Causes of Mortality	Yes	NA	No	0071
21 Plan All-Cause Readmission The percentage of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days, for members 18 years of age and older.	NCQA	Administrative	18% of Medicare patients admitted <sup>xvii</sup>	#3 Effective Care Coordination	No	NA	NA	No

	Measure	Steward	Data Collection Methodology	National Prevalence	National Quality Strategy	Proposed Adult Medicaid Set	CHIPRA Core Set	Meaningful Use Measure	NQF Endorsed
22	Prenatal and Postpartum Care The percentage of deliveries that received a prenatal care visit in the first trimester. Percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year that had a postpartum visit on or between 21 and 56 days after delivery.	NCGA	Administrative	4 million births per year <sup>xviii</sup>	#5 Supporting Better Health in Communities	Yes (postpartum)	Yes (prenatal)	No	No
23	Use of Appropriate Medications for People with Asthma The percentage of members 5-56 years of age who were identified as having persistent asthma and appropriately prescribed medication.	NCGA	Administrative	17.5 million adults <sup>xx</sup>	#3 Effective Care Coordination	Yes	No	Yes	0036
24	Use of Imaging for Low Back Pain Percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	NCGA	Administrative	Approximately 50% of adults will experience low back pain <sup>xx</sup>	#3 Effective Care Coordination	Yes	NA	No	0052

TABLE 2

## Citations

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