Mathematica
Progress Together

Quality Rating Systems in Medicaid Managed Care

Final Report

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Contents

Exhibits

Acronyms

- ACA: Affordable Care Act
- CAHPS: Consumer Assessment of Healthcare Providers and Systems
- CHIP: Children’s Health Insurance Program
- CMCS: Center for Medicaid and CHIP Services
- CMS: Centers for Medicare & Medicaid Services
- EQRO: external quality review organization
- HEDIS: Healthcare Effectiveness Data and Information Set
- MA: Medicare Advantage
- MAC: Medicaid and Children's Health Insurance Program
- MACPAC: Medicaid and CHIP Payment and Access Commission
- MCO: managed care organization
- QHP: Qualified health plans
- QRS: Quality rating system

Executive summary

Managed care has become the dominant form of service delivery for Medicaid and Children's Health Insurance Program (CHIP) beneficiaries (MACPAC 2020). In April 2016, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that requires states to implement a Medicaid and CHIP (MAC) quality rating system (QRS) (42 CFR § 438.334). Although states do not have to comply with this requirement until CMS finalizes and releases specific guidance, including a proposed and final Federal Register notice further defining the specific MAC QRS requirements, CMS clarified some of the federal QRS parameters in its November 2020 managed care final rule (CMS 2020).

The Medicaid and CHIP Payment and Access Commission (MACPAC) contracted with Mathematica to explore the design of QRSs in use on a voluntary basis by state Medicaid programs, how the systems work, how they compare with systems developed for other federal programs, and how they might evolve to comply with federal requirements. The primary goal of this study was to examine how states use QRSs to inform beneficiaries, incentivize health plan performance, and increase health plan accountability. A secondary goal of the study was to explore how state Medicaid programs align their QRSs with other quality initiatives and financial incentives to improve health plan performance.

While states are not yet required to have a MAC QRS, thirteen states are using rating systems in their Medicaid managed care programs. In conducting this research, Mathematica examined the use of Medicaid managed care QRSs in Florida, Michigan, Ohio, Pennsylvania, and Texas and the systems used in the Medicare Advantage (MA) program and the Marketplace for qualified health plans (QHPs). Mathematica reviewed publicly available documentation on each rating system and interviewed representatives from state Medicaid programs, health plans, and external quality review organizations as well as individual enrollment brokers, consumer advocates, CMS officials, and national experts.

This report profiles the QRSs of these five state Medicaid managed care programs and compares them with the rating systems used in the MA program and for Marketplace QHPs (hereinafter referred to as federal quality rating systems). Exhibit ES.1 contains an overview of several features of the state and federal quality rating systems profiled in this report.

Exhibit ES.1. Selected characteristics of state Medicaid managed care and federal quality rating systems in study

	Florida	Michigan	Ohio	Pennsylvania	Texas	Medicare Advantage	Marketplace qualified health plans
Year established[a]	2015	2003	2014	2012	2013	2009	2019[g]
Rating scale	5 stars	3 apples[f]	5 stars	4 stars	5 stars	5 stars	5 stars
Benchmark[b]	National	State-wide	State-wide	Regional	Regional	National	National
Rating domains[c]							
Child health	X	X	X	X	X		X
Child dental				X			X
Pregnancy	X	X	X	X	X		X
Adult health	X				X	X	X
Chronic Illness	X	X	X	X	X	X	X
Behavioral health	X						X

	Florida	Michigan	Ohio	Pennsylvania	Texas	Medicare Advantage	Marketplace qualified health plans
Access to care		X	X	X			X
Patient experience		X	X	X	X	X	X
Plan administration						X	X
Overall rating		X			X	X	X
Number of measures in most recent ratings[d]	27	46	59	32	12 (Child) 11 (Adult)	37	37
Display	Online	Paper and online	Paper and online	Paper and online	Paper and online	Online enrollment platform	Online enrollment platform
Alignment with financial and enrollment incentives for quality[e]							
Auto-assignment		X	X		X	Direct tie to payment and enrollment incentives	None
Capitation withhold	X	X	X				
Liquidated damages	X						
Pay-for-performance			X	X[h]	X		
Proportion of QRS measures also tied to financial incentives for quality	86%	61%	34%	31%	27% of adult measures	100%	N/A

Sources: Mathematica's 2020 review of public documents related to QRSs. MACPAC 2020.

[a] Year established is based on Mathematica's review of available documentation and the recollection of state Medicaid officials interviewed.

[b] Benchmarks refer to how the QRS assesses health plan performance and compares it with that of some comparative group. For each state QRS, the benchmark is other Medicaid managed care plans at the regional, state, or national level. For the Medicare Advantage and Marketplace QHP QRS, the benchmark is all other MA or QHPs, respectively, at the national level.

[c] Rating domains refer to grouped categories of quality measures that focus on similar populations, services, or topics. The Marketplace QHP QRS does not organized measures into domains but does include measures of each of the topics listed in the exhibit.

[d] Mathematica applied a consistent approach to counting measures across rating systems which counts composite measures as single measures. As a result, the number of measures reported in this report may differ from other sources.

[e] For the state QRS to align with financial incentives for quality, there must be overlap in the specific measures in the QRS with those programs.

[f] Michigan utilizes a 3-level rating system that ranges from 2 apples on the low end to 4 apples on the high end.

[g] The Marketplace QHP QRS program was originally established in 2014 and initially piloted in select states starting in 2016. In 2019, all states were required to implement a Marketplace QRS for QHPs.

[h] Ohio's pay-for-performance program was phased out beginning in 2018.

QRS = quality rating system.

Key findings

Six major themes emerged from this research. This report explores these themes in more detail and contains profiles of each rating system as appendices.

- **QRSs are designed to help beneficiaries understand performance differences among health plans.** The state and federal quality rating systems profiled in this report aimed primarily to show performance differences across health plans. Many of the methodological and design components of the rating systems reflect this goal. For example, most use five-category rating scales because that reflects enough variation in health plan performance to enable beneficiaries to differentiate among available health plans. Methodological approaches varied across the state Medicaid managed care QRSs and the federal quality rating systems, but most of the programs rate health plans based on observed variations in performance relative to other health plans rather than assessing performance against a predetermined threshold. Under this methodological approach, a health plan does not know in advance what performance level will produce a given rating. Instead, the QRS methodology produces a rating based on how that plan performed in the measurement period on given measures relative to other plans. State officials reported that this approach makes it easier for beneficiaries to see the relative differences among plans.
- **The primary goal of QRSs is to help inform beneficiaries about their health plan choices.** Across all five study states and federal programs, interviewees reported that the QRS is intended primarily as a tool to help beneficiaries select a health plan. Some states and CMS officials reported working with beneficiaries directly through focus groups and other methods, such as surveys, to develop and refine their rating systems. Federal and state officials also reported that they engage health plans and other stakeholders in developing these systems. In four of five states studied, beneficiaries receive the health plan quality ratings as part of the paper enrollment materials (in the fifth state, the QRS is available exclusively online). Beneficiaries can also find the ratings on each state's Medicaid website. This is different from Marketplace QHP QRS and MA's Part C and Part D Star Ratings (hereinafter referred to as MA QRS), which prominently display plan quality ratings in the online beneficiary enrollment platform.
- **Even so, it is unclear whether Medicaid beneficiaries use quality ratings to select health plans.** None of the study states actively track this. Medicaid enrollment brokers and beneficiary advocates suggested that beneficiaries prioritize provider networks and value-added services when selecting a health plan. All enrollment brokers interviewed shared that information regarding health plan quality was not included in their state-approved scripts, which are used to guide health plan selection when working with beneficiaries.
- **A secondary goal of QRSs is to improve health plan performance, and most study states reported aligning key quality measures in the QRS with financial incentives to further these efforts.** Most interviewees shared that the QRS is an important tool for improving health plan performance. All five study states align the quality measures used in the QRS with those used in financial incentives in some way. For example, similar measures might be used to calculate plan ratings in the QRS and determine auto-assignment for beneficiaries who do not self-select a plan or in pay-for-performance incentives. MA is the only program in the study that directly ties health plan ratings to payments; in MA, plans with a four- or five-star overall rating receive a quality bonus payment, and five-star plans receive enrollment preferences.
- **The study states do not use the QRS for managed care oversight and accountability purposes.** Although most states reported monitoring health plan performance on specific quality measures over time, they do not use the QRS ratings to sanction poorly performance plans. This differs from the Marketplace QHP and the MA program, which explicitly use the QRS for oversight and accountability purposes. For the Marketplace QHP, reporting the quality measures used in the QRS is a certification requirement and CMS uses the QRS to facilitate oversight of Marketplace QHP

issuers' compliance with these requirements. In MA, plans that consistently perform poorly receive warning letters and ultimately face termination from the program if they have an overall rating of 2.5 stars or lower for three consecutive years.

- **The study states generally support greater alignment of QRSs across states and programs but would like future CMS rulemaking to allow for flexibility.** State officials interviewed generally felt confident that their state QRS could come into compliance with federal Medicaid managed care QRS requirements, and several noted that they participated in CMS's ongoing engagement with the states on this topic. Although many state officials and stakeholders agreed that a common set of measures would enable greater cross-state comparison, some state officials noted that they want to maintain the flexibility to select performance measures that are important to their particular state and region.

Section 1. Introduction

Managed care has become the dominant form of service delivery for Medicaid and Children's Health Insurance Program (CHIP) beneficiaries (MACPAC 2020). In April 2016, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that requires states to implement a Medicaid and CHIP (MAC) quality rating system (QRS) (42 CFR § 438.334). States do not have to comply with this requirement until CMS releases specific guidance on MAC QRS, but states will have three years from the date a final notice is published in the Federal Register to come into compliance. CMS modified this requirement in its November 2020 managed care final rule (CMS 2020). The November 2020 managed care final rule clarified several aspects of MAC QRS requirement, and all provisions in the 2020 final rule are now in effect (CMS 2020). The rule:

- Added a requirement for CMS to develop a set of mandatory performance measures
- Expanded the scope of alignment of the MAC QRS and the minimum measure set with the Medicaid Scorecard initiative and other CMS managed care rating systems
- Emphasized CMS' intention to consider feasibility when assessing whether an alternative state QRS is comparable to a CMS-developed QRS
- Described CMS' intention to consult with states and other stakeholders in developing the sub-regulatory guidance

The Medicaid and CHIP Payment and Access Commission (MACPAC) contracted with Mathematica to explore the design of QRSs in use by state Medicaid programs, how the systems work, how they compare with systems developed for other federal programs, and how they might evolve to comply with federal requirements.[1] The primary goal of this study was to examine how states use QRSs to inform beneficiaries, incentivize health plan performance, and increase health plan accountability. A secondary goal of the study was to explore how state Medicaid programs align their QRSs with other quality initiatives and financial incentives to improve health plan performance.

While states are not yet required to have a MAC QRS, thirteen states are using rating systems in their Medicaid managed care programs. In conducting this research, Mathematica examined the use of Medicaid managed care QRSs in Florida, Michigan, Ohio, Pennsylvania, and Texas and compared these systems with those used in the Medicare Advantage (MA) program and the Marketplace for qualified health plans (QHP).

This report presents findings from Mathematica's research on the use of QRSs in Medicaid managed care programs. Section 2 provides background on the use of QRSs in Medicaid managed care and an overview of the use of rating systems in other federal programs. Section 3 describes the methods used in this research, including an inventory of research questions and the methods used to answer each question. Section 4 presents findings related to developing and implementing QRSs; their design and methodology; the use of QRSs by beneficiaries, health plans, and states; state preparations to comply with CMS requirements for a MAC QRS; and the impact of the rating systems. Section 5 contains conclusions. Detailed profiles for each of the rating systems studied appear as appendices to this report.

[1] The scope of this study focuses exclusively on Medicaid managed care programs and does not extend to CHIP managed care plans.

Section 2. Background

The MAC QRS is one of several strategies intended to align and enhance states' Medicaid quality measurement and improvement at multiple levels of accountability. The CMS Medicaid and CHIP Core Sets of Health Care Quality Measures provide public accountability for Medicaid and CHIP quality performance at the state level on the quality of care and health outcomes for Medicaid and CHIP beneficiaries (Medicaid n.d.a). The CMS MAC Scorecard initiative provides insight into federal monitoring of Medicaid health system performance (Medicaid 2020). States must also have a managed care quality strategy specific to improving outcomes in Medicaid and CHIP, and these priorities are typically aligned with the reporting requirements included in health plan contracts (Medicaid n.d.b). The MAC QRS complements these state and federal efforts by focusing on performance on quality measures at the health plan level. Together, these strategies are intended to support broader Medicaid and CHIP quality goals, drive delivery and payment reform initiatives, and inform managed care value-based payment arrangements.

This section describes the current use and design of QRSs in state Medicaid managed care programs and in federal reporting programs, including the MA and Marketplace QHP rating systems, and describes the federal requirements related to a MAC QRS.

A. Use of QRS in state Medicaid programs

CMS policy objectives of a MAC QRS

- To hold states and plans accountable for the care provided to beneficiaries
- To empower beneficiaries by providing them with information about available plans
- To drive improvement in plan performance and quality of care

As of July 2019, 40 states use risk-based managed care to deliver care to their Medicaid beneficiaries (Hinton et al. 2020). States vary in the number and types of Medicaid managed care plans they offer, the geographic areas served, the services covered, and the populations enrolled. States also vary in their capacity to gather and report standardized measures of health plan performance (MACPAC 2020). In all, 16 states publicly report plan-level quality performance information that meet at least some of the policy objectives of a MAC QRS outlined in the call-out box in this section. Of those, 13 states established QRSs that provide beneficiaries with a summary rating of overall plan performance or plan performance at the domain level; the remaining three states report quality measure performance without any summary ratings at the domain or overall level.

Previous research on the use of QRSs in Medicaid suggests that existing state Medicaid QRSs vary widely in their design and use. They use different performance measures to inform beneficiaries than those they use for plan monitoring and oversight purposes (Mathematica n.d.). There is very little evidence that public reporting of quality information impacts beneficiary choices; one of the few studies shows that beneficiaries may not use quality information in health plan selection because the information is not easy to interpret or too complex to navigate, or because they have doubts about the value of the information provided in the rating system (Totten et. al. 2012).

State rating systems vary in the measures and reporting formats they use and in their summary scoring conventions. In most instances, the publicly reported rating systems rely on a subset of the Healthcare

Effectiveness Data and Information Systems (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures that states use for managed care oversight and performance improvement. Most existing state QRSs aggregate individual quality measures that focus on similar populations, services, or topics into domains of quality. For example, many state rating systems calculate a domain-level rating of children's health care, which includes measures on receipt of well-child visits or immunizations. Other common domains in state rating systems include women's health, chronic conditions, behavioral health, and beneficiary satisfaction measured using CAHPS surveys. A smaller number of state rating systems also calculate an overall quality rating or publish ratings at the measure level to help beneficiaries interpret performance on any individual measure.

The 13 states with an established QRS reviewed by Mathematica vary in the methodology used to calculate health plan ratings, using different benchmarks against which they assess plan performance and assign ratings. The most common approaches to benchmarking are to compare health plan performance with that of all other plans state-wide or with national benchmarks of Medicaid plan performance. A less common approach to benchmarking is to generate ratings for plans operating in specific regions of the state.

States also vary in the extent to which the measures included in the QRS align with those used in the state's other quality improvement and payment reform initiatives. Generally, the quality measures used in the state QRSs and those in the Medicaid and CHIP Core Sets of Health Care Quality Measures align to some degree because both sets of measures draw heavily from HEDIS, which is specifically designed for managed care plan quality reporting. States often use these same measures for other purposes, including capitation withholds, pay-for-performance programs, state-directed payment arrangements, evaluation of plan bids as part of the procurement process, and auto-assignment algorithms to assign beneficiaries to a health plan when they have not actively chosen one.

B. Use of QRS in federal programs

CMS has a history of using QRSs at the health plan and provider levels. At the provider level, CMS has the Care Compare tools, which generate ratings for different provider types in the Medicare program, including clinicians, hospitals, nursing homes, home health services, hospice care, inpatient rehabilitation facilities, long-term care hospitals, and dialysis facilities (Medicare n.d.c).

At the health plan level, CMS calculates ratings for MA plans and Marketplace QHPs. These federal rating systems are of greatest interest to this study because the MAC QRS regulations specifically reference those programs and because they use health plan-level quality scores similar to many of the current rating systems for Medicaid managed care. These are described briefly here; this report includes other elements of these rating systems throughout.

Medicare Advantage Star Ratings

The MA Part C and Part D Star Ratings program (hereinafter referred to as the MA QRS) was established in 2007 and first published star ratings in 2009. CMS rates MA plans using a five-star rating scale, in which five stars represents the highest performance. The ratings are calculated based on the plan's performance across 46 quality measures, which include measures of clinical quality, beneficiary experience and satisfaction, and plan administrative performance (MedPAC 2019). CMS updates the ratings annually and integrates them into the enrollment platform used by beneficiaries to finalize their plan selections.

In addition to using the MA star ratings as a tool for beneficiary choice, CMS also incentivizes plan performance through payment mechanisms based on these ratings. The Affordable Care Act (ACA) required that CMS implement a quality bonus program for MA plans based on their star ratings. Under this program, MA plans that receive a four- or five-star overall rating are eligible for bonus payments they can use to offer additional benefits to beneficiaries enrolling in the plan (MedPAC 2019). The highest-performing plans receive enrollment privileges; Medicare beneficiaries enrolled in a plan rated four stars or below can switch to a five-star plan once during the year.

CMS conducts an annual review of the measures used for star ratings that assesses the reliability of the data, clinical recommendations, and feedback received from stakeholders. CMS seeks stakeholder feedback on proposed changes to the star rating methodology by releasing a formal request for public comment.

Marketplace QHP QRS

The ACA required the establishment of a QRS for QHPs offered on the federally facilitated or state-based exchanges (or Marketplaces). A small number of states piloted the rating system for the 2017 plan year, and it rolled out nationally for the 2020 plan year, with star ratings published nationwide for the first time in 2019. As with MA QRS, CMS calculates ratings for health plans using a five-star scale and publishes the ratings on Healthcare.gov (for federally facilitated exchanges), and states publish the ratings on their Exchange websites. CMS calculates the ratings annually and displays the overall rating and summary indicator ratings on HealthCare.gov. Like MA, the Marketplace QHP QRS is a tool for consumer decision-making, regulatory oversight, and health plan internal quality improvement; however, in its current state, there are no payment incentives tied to plan performance with the Marketplace QRS.

For 2020, the QRS measure set includes 37 measures, which area combination of clinical quality measures and a subset of QHP Enrollee Survey response data. The QRS hierarchy includes an overall global rating, three summary indicator ratings, seven domain ratings, and 13 composite scores. The summary indicators include (1) member experience, (2) medical care, and (3) plan administration. The summary indicators are calculated based on seven domain ratings, which include (1) access and care coordination, (2) doctor and care, (3) clinical effectiveness, (4) patient safety, (5) prevention, (6) efficiency & affordability, and (7) plan service.

Similar to MA, CMS continuously refines the QRS program and the QHP Enrollee Survey based on stakeholder feedback, clinical guideline changes, administration priorities, and advances in quality measurement and survey administration. CMS seeks stakeholder feedback annually through the QRS and QHP Enrollee Survey Call Letter process as well as through technical expert panels. The CMS Office of Communications holds focus groups with consumers to test any planned changes to the Healthcare.gov interface, where the Marketplace QHP ratings are displayed.

C. Overview of federal requirements for a MAC QRS

In April 2016, CMS issued a final rule that requires states to implement a MAC QRS that aligns with the summary indicators of the Marketplace QHP QRS (42 CFR § 438.334). The 2016 rule requires all states contracting with managed care organizations (MCOs), prepaid inpatient health plans, or prepaid ambulatory health plans to adopt the CMS-developed QRS framework or a substantially comparable alternative QRS. States must collect data from each MCO and issue an annual quality rating for each health plan and prominently display the rating on the state's Medicaid website. In addition, the 2016 rule

requires CMS to develop an external quality review protocol for an optional activity to assist with plan ratings. After CMS releases a final QRS notice in the Federal Register on the CMS-developed QRS framework and methodology, states will have three years to implement their QRS (or a substantially comparable alternative) and comply with the regulations.

CMS issued a final Medicaid managed care rule in November 2020 (CMS 2020). In it, CMS made several changes to the QRS requirements:

- **Ongoing engagement with stakeholders:** CMS clarified that it will continue to consult with states and other stakeholders in the process of finalizing QRS requirements through rulemaking.
- **Mandatory performance measures:** CMS will require all states, whether using the CMS-developed QRS or a state alternative QRS, to use a mandatory set of measures. CMS signaled that it intends to align the mandatory measures with those used in the Medicaid and CHIP Scorecard initiative. CMS signaled that this mandatory set of measures would constitute a floor rather than a ceiling and that states will be able to include additional measures, whether they implement the CMS-developed QRS or a substantially comparable state alternative QRS.
- **Alignment with other rating systems:** CMS expanded the range of other federal programs with which it will align the MAC QRS. The 2016 rule only included the Marketplace QHP QRS, but the 2020 rule included alignment with other initiatives, including the MA QRS and the Medicaid and CHIP Scorecard initiative, which includes measures from the Child and Adult Core Sets.
- **State alternative QRS:** CMS made explicit its intention to consider feasibility when determining whether state alternative QRSs produce substantially comparable information to the CMS-developed QRS. The revised rule states that CMS will review whether a proposed state alternative QRS is "to the extent feasible, taking into account such factors as differences in covered populations, benefits, and stage of delivery system transformation, to enable meaningful comparison of performance across States." (42 CFR 438.334(c)(ii)). States pursuing an alternative QRS will have to submit their QRS framework, measures, and methodology to CMS for review before implementing an alternative QRS. They will also have to receive input from their medical care advisory committee and the public.

CMS plans to issue a proposed and final QRS-specific notice in the Federal Register as well as additional guidance that will detail performance measures, a subset of minimum mandatory measures and methodology, and define the substantially comparable standard, although it has not indicated when it will do so. The proposed MAC QRS-specific Federal Register notice will be subject to public comment. After CMS finalizes the MAC QRS-specific Federal Register notice, states will have three years to comply.

The 2020 final rule also amended regulations related to managed care payment, network adequacy standards, risk sharing mechanisms, and appeals and grievances processes and requirements for beneficiary information (CMS 2020). Relevant to topics discussed in this report, the rule gave states additional flexibility to determine provider network adequacy by removing the requirement that states set time and distance standards. It also loosened the requirements for states to make written materials accessible to people with disabilities and those who do not speak English and changed the requirements and time frames for beneficiary grievances and appeals (Hinton and Musumeci 2020).

Section 3. Methods

MACPAC engaged Mathematica to examine how states use QRSs to inform beneficiaries, incentivize health plan performance, and increase health plan accountability; analyze five state Medicaid rating systems in-depth and compare them with two federal rating systems; and understand how states might be preparing to comply with forthcoming federal requirements. To conduct this study, Mathematica collected and reviewed publicly available information and held key informant interviews with state and national stakeholders. This section provides more information on the methods used in this research.

Exhibit 1 contains MACPAC's research questions addressed in this study. It also indicates which methods served to answer each question and which section of this report provides more information on each topic.

Exhibit 1. Research questions and methods used to answer them

Research question	Section of report	Document review	State interviews	Stakeholder interviews
How are states designing their QRSs, and how do they compare to each other and CMS-designed systems for MA and QHP?	4.B	X	X	X
To what extent are states using other quality or plan performance measures to inform beneficiaries, incentivize plan performance, and conduct plan oversight?	4.B	X	X	
How are states using their QRSs to improve beneficiary information about plan performance?	4.C	X	X	
Are states tying MCO ratings to financial or enrollment incentives?	4.C	X	X	
Are states using the ratings for oversight or procurement purposes?	4.C		X	
How are states planning to comply with federal requirements related to QRSs?	4.D	X	X	X
Are QRSs having an effect on beneficiary choice or MCO behavior?	4.E		X	X

Notes: State interviews refer to those with state Medicaid officials, health plans, enrollment brokers, external quality review organizations, and beneficiary advocates that are unique to each of the five states in the study. Stakeholder interviews refer to national experts and CMS officials.

CMS = Centers for Medicare & Medicaid Services; MA = Medicare Advantage; MCO = managed care organizations; QHP = qualified health plans; QRS = quality rating system.

A. State selection

Mathematica identified 16 states that publicly report quality performance information for health plans, which formed the sample of potential states for inclusion in this study. Mathematica narrowed the selection criteria to include those states that included a summary rating of overall health plan performance or plan performance at the domain level. Mathematica excluded four states that:

- Only report quality measure scores, without any summary ratings. This led to removing Arizona, California, and Massachusetts from the study.
- Only report one overall quality rating, without any measure- or domain-level information. This led to removing South Carolina from the study.

Exhibit 2 presents the selection criteria used to select five states for inclusion in this study. Mathematica assessed each state against the criteria in Exhibit 2 to select the five states for inclusion in consultation with MACPAC. The five states—Florida, Michigan, Ohio, Pennsylvania, and Texas—included in this research are geographically diverse and vary in the complexity of their managed care environments and populations included in their QRSs. They also differ in their QRS design and reporting components, which enabled analysis of a wide range of rating system features.

Exhibit 2. Criteria for state selection

Criterion	Rationale for inclusion
Geographic location	Select states with an eye toward geographic variation.
Number and complexity of Medicaid managed care plans offered and included in the state QRS	Include variation in the complexity of the managed care environment in the states selected. For example, consider states that have several plans offered at the county or regional level as well as states that have plans that operate statewide.
Medicaid populations covered	Select states that cover different populations through their Medicaid programs; this includes considering their Medicaid expansion status.
History and evolution of state's QRS	When possible, include states with QRSs at different stages of maturity. Including states that only recently launched their QRS could yield insight into how states that do not have a QRS have to prepare to comply with the forthcoming federal rule. States that have a longer QRS history might have insight into the evolution of rating systems and a deeper investment in their own system, affecting how they respond to federal requirements.
Variations in QRS performance measures and score methodologies	States might select different quality measures for their QRS, use different methods to calculate summary ratings, and use different performance benchmarks in displaying plan-level information.
QRS reporting formats and public interfaces	Some states publish their ratings in static PDF-based report cards, and others use a more dynamic, web-based interface.
Approaches to managed care oversight or payment and delivery reform, including performance incentives and auto-assignments of Medicaid beneficiaries	States vary in how they use their QRS for plan oversight or performance improvement.

QRS = quality rating system.

B. Document review and profiles

After finalizing the state and federal quality rating systems for inclusion in the study, Mathematica reviewed the publicly available information for each one to develop a basic understanding of the measures reported, the methods used to calculate health plan ratings, the comparative benchmarks used to rate health plan performance, how information is displayed for beneficiaries, and how the QRS is used in health plan oversight and monitoring.

The types of documents reviewed for each rating system included the following:

- State Medicaid websites
- The CMS websites for the MA and Marketplace QHP QRSs, including technical specifications and the record of federal rulemaking related to the QRSs
- Medicaid managed care enrollment reports
- State Medicaid external quality review reports
- Medicaid managed care health plan contracts
- State Medicaid managed care quality strategies
- Methodological or technical details on the rating system

Information extracted from the document review contributed to preliminary state and federal quality rating system profiles detailing various aspects of the QRS design, methodology, and use. The document review also identified gaps that required more input from stakeholders during the interview process. Representatives of state and federal quality rating systems reviewed the preliminary profiles before Mathematica interviewed them. In most cases, stakeholders provided written feedback on the preliminary profiles to correct inaccuracies or provide additional detail. Final state and federal quality rating system profiles appear as appendices to this report.

C. Key informant interviews

Mathematica interviewed representatives from each state included in the study as well as CMS officials and national experts. Mathematica collected data via qualitative interviews with state Medicaid officials in each of the five states, representatives from MCOs in each state, beneficiary advocates, enrollment brokers, and external quality review organizations. Mathematica conducted interviews with CMS officials responsible for the MA QRS and the Marketplace QHP QRS as well as representatives from the Center for Medicaid and CHIP Services (CMCS) responsible for the MAC QRS requirements. Mathematica also interviewed national experts, including a panel of nonprofit health plans in states outside the study that also have a QRS. Appendix H contains a full list of the organizational affiliations of each interviewee.

Exhibit 3 presents the categories of stakeholders interviewed and selected interview topics discussed with each group. A semi-structured interview protocol guided each interview, tailored for each state and stakeholder group based on the information gleaned from the document review. Interviews took place via telephone, were recorded with participants' consent, and were uploaded via a secure server to a professional transcription service. After review by the research team for accuracy, transcripts were coded using the qualitative analytic software NVivo. Interviews took place from August to October 2020.

Exhibit 3. Interview topics, by stakeholder group and research topic

Selected interview topics	Stakeholder group						
	State Medicaid officials	MCO representatives	EQRO representatives	Enrollment brokers	Beneficiary advocates	CMS officials	National experts
State Medicaid managed care environment							
Development and evolution of the state's QRS	X	X	X		X		
How the state uses the QRS to meet its quality goals	X						
Anticipated future changes to the QRS	X						
QRS components and characteristics							
Experience reporting measures or other information for QRS purposes		X					
How the QRS has affected MCO quality improvement activities		X	X				
Intended use of QRS							
How the QRS is used to inform beneficiary choice	X			X	X		
How the QRS is used in beneficiary enrollment and outreach	X			X	X		
Performance measures to inform beneficiaries, incentivize plan performance, and increase plan accountability							
Experience reporting performance measures for QRS purposes		X	X			X	
Experience with financial or enrollment incentives tied to QRS performance	X	X				X	
Comparison with other federal QRSs							
How the MAC QRS might compare with other CMS initiatives		X				X	X
Technical assistance needs in other federal QRSs						X	X
Preparation to comply with federal QRS requirements							
Successes and challenges in developing and implementing QRSs	X		X			X	X
Technical assistance resources that states might need to comply with federal QRS requirements						X	X

CMS = Centers for Medicare & Medicaid Services; EQRO = external quality review organization; MAC = Medicaid and CHIP; MCO = managed care organization; QRS = quality rating system.

D. Limitations of the study

Mathematica performed interviews for this report from August to October 2020, before CMS finalized its 2020 managed care rule. Mathematica chose the states in this study because their rating systems were mature and the states had a demonstrated history of using quality measurement to incentivize health plan performance. Therefore, the lessons learned from these five states might not apply to states that do not currently report any health plan performance information and will have to develop new processes and systems in order to come into compliance with the CMS MAC QRS requirements. Mathematica did not interview Medicaid beneficiaries for this research so references to beneficiary preferences are from the perspective of other stakeholders interviewed.

Section 4. Findings

A. Developing and implementing rating systems in the study

Feedback gathered from states and other stakeholders that participated in this study shed light on the goals of the QRSs, the initial development processes, procedures for updating measures and data, and changes to the QRSs over time.

Goals of the QRS

Representatives from all the study states and those responsible for federal quality rating systems agreed that the primary goal of their respective QRS was to support beneficiaries' decision making. This goal aligns with what CMCS anticipates will be the primary policy objective of the MAC QRS: to help beneficiaries select health plans. Despite this broad consensus, there is little evidence that beneficiaries use rating systems to inform their plan selection. None of the states interviewed tracked information on beneficiaries' use of the QRS, nor did any of the states direct their enrollment brokers to instruct beneficiaries to use the QRS. See Section 4.C for more information on this theme.

> **"We really wanted to have something consumers could easily use to help in choosing a plan [on Medicaid]."**
>
> ***State Medicaid official***

Although the primary goal of the QRSs is as a beneficiary tool, several interviewees believed the ratings could serve multiple purposes. For example, several interviewees noted that QRSs can improve health plan performance through the transparent reporting of quality information and foster competition among health plans. Ohio state Medicaid officials shared that part of the goal for developing a QRS was that they believed plans would "work hard to outrank each other" on the measures included in the QRS. In the MA QRS, CMS officials reported that health plans pay very careful attention to their performance compared with those competing in the same markets. This could be because the star ratings tie directly to a bonus payment incentive and are prominently displayed within the enrollment platform. More detail on how states use the QRS quality measures for other purposes is discussed in Section 4.C.

Initial development of the QRS

QRS development processes vary. For example, in Florida, Pennsylvania, and for the MA rating system, the QRS evolved from an existing quality reporting dashboard into a more user-friendly star rating system. States that kept records of their initial QRS development generally had a one- or two-year process of development before implementation (Texas, Florida, Michigan). Although no states piloted their QRS before official roll-out, the Marketplace QHP QRS was piloted for two years before going live nationwide in 2019.

States involved an array of stakeholders, including beneficiaries, health plans, and other groups (for example, beneficiary advocacy groups or quality committees from the state's health plan associations) in planning and implementing the QRS. Stakeholders provided feedback through various forums, including meetings, written comments, and informal phone calls. The two federal quality rating programs, MA and Marketplace QHP, reported similar stakeholder engagement approaches for their initial development. State and CMS officials frequently used stakeholder comments to shape components of the QRS, such as measure selection, methodology for calculating ratings, and information presentation to the beneficiaries.

External quality review organizations (EQROs) played an important role in development and maintenance of Medicaid QRSs. Michigan and Texas engaged their EQROs in early conversations about the QRS and sought their feedback on the rating methodology and measures included. In Michigan, Ohio, and Texas, EQROs have an ongoing role in calculating the star ratings each year for the state.

Review and updates to QRS methodology over time

All the state and federal QRSs generally have a well-defined process for reviewing and updating the QRS; this process usually occurs annually. The states, however, approach this review and update process differently than the federal quality rating systems. While the federal rating systems require public comment and sometimes seek input from technical expert panels, none of the study states have an official process for beneficiaries and stakeholders to provide feedback as part of annual updates. In some cases, states request targeted feedback from health plans or other stakeholders depending on the extent or type of change to the QRS being considered in a given year, but these opportunities are not part of a formalized effort in the states. Per the 2016 final rule, states will be required to provide a minimum 30-day period for public comment if they opt to implement a substantially comparable alternative QRS.

States have made many changes to their QRSs through these periodic reviews. The most common change was to retire or add quality measures based on changes made by measure stewards and other reporting programs. Some states have made more significant changes to the QRS:

- Ohio and Texas changed their star rating scales from a three-category to a five-category rating scale. State officials reported they did so to better distinguish health plan performance and give beneficiaries more useful information when selecting plans.
- Michigan added an overall quality rating to its QRS in 2020 that summarizes the domain scores. It also incorporated additional CAHPS measures in the rating system that were not included in any of the existing domain scores.
- Pennsylvania restructured its QRS to rate health plans on domains, which combine related quality measures. Previously, Pennsylvania reported health plan performance on individual measures, but consumer feedback indicated that the measure presentation was confusing.

The two federal quality rating systems for MA and QHP plans also changed over time. For example, the Marketplace QHP QRS shifted after the pilot to give greater weight to the medical care summary indicator instead of the other summary indicators (member experience and plan administration) in an effort to align with the volume of measures in each summary indicator. The MA QRS moved from a three-star rating system to a five-star rating system. Overall, the states and the federal quality rating systems agreed that their respective QRSs have not changed drastically over time and health plan representatives appreciated the stability of the rating systems.

"From my perspective, there haven't been a lot of changes [to the QRS]…So it's been relatively consistent, but I wouldn't say that's necessarily a bad thing.
Health plan representative

B. QRS design and methodology

State and federal quality rating programs design their rating systems in different ways depending on their stated policy objectives. This section presents information on the populations covered by the QRSs in this study, the individual quality measures used to calculate health plan ratings, the rating scales and

methodology for calculating ratings, and benchmarking approaches states and federal quality rating systems use, including risk adjustment.

Types of managed care plans and populations included in QRSs

Most states only include comprehensive MCOs in their rating systems and are not rating specialty health plans or services carved out of their comprehensive plans. Comprehensive MCOs are those that provide comprehensive benefits (for example, acute, primary care, specialty care) and serve most Medicaid and CHIP beneficiaries. Specialty plans are those that serve populations with special needs, including those needing long-term services and supports or behavioral health services, and children with special health care needs. Two states in our study, Texas and Florida, include specialty plans in their rating system. Florida's QRS rates specialty plans within the same platform as comprehensive MCOs but includes an indicator of which plans are specialty plans and therefore might serve a different population than comprehensive plans. Texas has a separate rating system for some of its specialty plans, including those specifically for people with disabilities. One health plan representative thought that specialty plans should be compared and displayed separately from comprehensive MCOs so that only similar plans are being compared.

Quality measures included in QRSs

In selecting the individual quality measures that go into health plan ratings, state rating systems largely rely on the measures in the Medicaid and CHIP Core Sets and other HEDIS or CAHPS measures in their rating systems. On average, about half the QRS measures in the study states were also Medicaid and CHIP Core Set measures, though this ranged from about 36 percent of measures in Michigan to 65 percent of measures in Florida. Some states, such as Pennsylvania, have added state-specified quality measures to their rating systems as well. Health plan contracts dictate which measures health plans must report to the state, and then the state selects among the reported measures that are most relevant for the purposes of the QRS.

"There are measures [on the QRS] that ask about things that are related to really the providers and the network, rather than what the health plan is doing…But I still feel like the health plan is responsible for the providers they have in their network, and if they have good providers in their network, then they should get good ratings."

Representative of a health plan association

Measures included in the state QRSs include components of health service delivery that are influenced more by providers alongside those that are within the direct control of the health plan. For example, measures of childhood immunizations assess provider effectiveness, while member ratings of health plan customer service reflect plan performance. Some stakeholders interviewed reflected on the challenges of using measures in the QRSs for varying levels of responsibility while others felt that measuring performance of both providers and the health plan within the QRS further ensures alignment of provider and health plan priorities with the state's quality strategy.

As CMCS develops a MAC QRS framework, officials are considering how to design a system that rates plan performance on measures that are most meaningful to beneficiaries in selecting health plans. In selecting a mandatory set of performance measures, CMS is considering incorporating non-clinical measures related to access, provider networks, customer service, and plan administration. During an interview with CMCS, officials referenced their work is based on human-centered design, an approach

which uses tools like interviews and direct observation of how beneficiaries and their caregivers navigate online health information resources. Using these approaches, CMCS officials found that many beneficiaries and their caregivers find value in non-clinical measures. Such measures would be a departure from most measures currently used in state QRSs, which tend to reflect clinical measures.

The federal quality rating systems include some measures of health plan compliance with regulatory requirements, such as those related to member complaints or customer service. The MA rating system is the only one studied that includes a measure that shows how much the plan's performance improved or declined from one year to the next.

Rating scales and approach to calculating health plan ratings

All the rating systems in this study calculate a rating at the domain level, which group together measures of similar concepts such as clinical services or beneficiary experience. For example, the Michigan QRS domain related to maternity care includes the Prenatal and Postpartum Care HEDIS measures. Some of the rating systems, such as those in Michigan, Texas, MA, and Marketplace QHPs, also calculate an overall health plan quality rating. In general, state Medicaid officials reported that ratings at the domain level help beneficiaries find information on services most relevant to them and evaluate the quality of the plan based on their individual or family health needs and preferences. For example, those selecting a plan for their children might be more concerned with how the plan performs on quality measures related to care provided to children and less interested in the plan's performance providing care to adults with chronic health conditions.

Common QRS domains

- Children's health care
- Women's health and pregnancy-related care
- Chronic conditions
- Behavioral health
- Beneficiary satisfaction

Five-category rating scales were the most common in the state and federal quality rating systems. Several states reported switching from a three-category rating scale to a five-category scale to enable further differentiation between plans, as three-category rating scales only report if health plans performed above or below average performance, which representatives from states felt did not reflect the distribution of health plan performance. Stars were the most common icon used to denote plan ratings, though Michigan used an apple icon.

During an interview, CMCS officials reported that the MAC QRS would evolve over time given that state Medicaid and CHIP programs are at very different starting points in the development of a MAC QRS. For example, CMCS officials reported that they are carefully considering whether the scope of the first iteration of the MAC QRS would include aggregating measure-level performance scores to derive a star rating. Additionally, CMCS officials report that their work with beneficiaries and their caregivers suggests a preference for measure-level performance scores over star ratings, as well as confusion over what the star ratings represent and who calculates them. Some rating systems already have a venue for reporting measure-level scores (Florida, Pennsylvania, MA), while representatives in other states reported that measure-level scores do not provide meaningful information for beneficiaries and might be difficult for a lay audience to interpret.

Exhibit 4, taken from Texas's QRS report cards, is an example of state plan rating displays reviewed in this study. The overall plan quality rating appears at the top of page along with ratings at the domain level

(for example, experience of care or staying healthy) and then ratings at the measure level. For plans that are too new to rate or did not have sufficient data to calculate a rating, the state adds a footnote explaining the interpretation of the missing rating.

Exhibit 4. Example health plan rating display

HEALTH PLAN PERFORMANCE

Ratings are based on a scale of one to five stars. Fewer stars mean the health plan has lower performance than other health plans, but this does not always mean bad performance.

★★★★★ Highest Performance in STAR

★ Lowest Performance in STAR

	Plan 1	Plan 2	Plan 3
Overall Health Plan Quality	★★★	★★★★	★★★★
Experience of Care	★★	No rating†	★★★
People get the care they need without problems or long waits	★★★	No rating†	★★★
Doctors listen carefully, explain clearly and spend enough time with people	★★★	No rating†	★★★
People give high ratings to their personal doctor	★★	No rating†	★★★
People give high ratings to the health plan	★★	★	★★★
Staying healthy	★★★★	★★★	★★★★
Women get checkups during pregnancy	★★★★	★★★	★★★★
New mothers get checkups after giving birth	★★★★★	★★★★	★★★★
People get regular yearly checkups	★★★	★★★★	★★★★
Women get regular screenings for cervical cancer	★★★	★★★	★★★★
Common Chronic Conditions	★★	★★★★	★★★
People get care for depression and constant low mood	★★	★★★★	★★★
People get care for diabetes	★★	★★★★	★★★

† If a plan shows "No rating": this is not a bad rating.
At the time of the study, the plan either: (1) was new to the area or (2) did not have enough information to rate.

TEXAS Health and Human Services

Source: Texas Health and Human Services n.d.

QRS benchmarking approaches and risk adjustment

The most common methodology for calculating ratings is sometimes referred to as a tournament approach (Michigan, Ohio, Pennsylvania, Texas, MA, and Marketplace QHP), which compares plan performance and assigns health plan ratings based on the distribution of observed performance in a given time period within the geographic unit for comparison (for example, regional, statewide, or national) rather than clinical thresholds. State and federal programs that use this approach reported it provides more meaningful information to support beneficiaries' choice by differentiating health plan performance among the plans available in each state or region. This approach also gives health plans an incentive to improve their rating by improving their performance relative to other health plans in the state or region.

Florida was the only state in this study that assigns ratings based on the percentiles of national Medicaid performance on HEDIS measures. Under this approach, health plans know that they have to score better than 50 percent of all Medicaid plans nationally to receive a five-star rating on a given measure in

Florida's QRS. Florida Medicaid officials reported that this provides an objective standard to compare health plan performance.

The rating systems in this study benchmarked health plan ratings using: (1) regional benchmarks that compare a health plan's performance with other Medicaid health plans in a sub-state region or county, (2) statewide benchmarks that compare a health plan's performance with all other Medicaid health plans in the state, or (3) national benchmarks that compare a health plan's performance with all other Medicaid health plans in the country. The Marketplace QHP and MA QRSs use national benchmarks to compare a health plan's performance with other MA or QHPs in the country.

Texas and Pennsylvania rate plans regionally.[2] These states shared that beneficiaries select plans and providers in their geographic region, so therefore a regional benchmark captures the most local and relevant range of choices available to beneficiaries. Michigan and Ohio use statewide benchmarks. The rationale for a statewide benchmark seemed primarily to be feasibility and the challenges related to disaggregating health plan performance at the regional level. For example, Michigan shared that it considered using a regional benchmark at one point, which might be more meaningful for beneficiaries, but methodologically, it is easier for the state to calculate ratings at the state level and less burdensome for plans to report statewide rates. Florida was the only state QRS to use a national benchmark.

"If we're asked to [benchmark] regionally, we have to administer regionally and track and identify [beneficiaries] per region. So it's a lot of things which need to be done in order for us to perceive variations in the regions."

State Medicaid official

Interviewees shared that the use of national benchmarks captures the largest denominator and sets the highest bar for performance. Representatives from MCOs, however, prefer statewide or regional benchmarks because of the range of maturity in Medicaid managed care programs across the country and differences in program design and populations across states. CMCS seems to favor a statewide benchmark in the first iteration of the MAC QRS. Texas is particularly concerned that CMCS will require it to abandon its regional rating system for a statewide benchmark, which it thinks would be less meaningful for its beneficiaries.

Except Texas and MA, the rating systems in this study do not risk adjust measures based on differences in the characteristics of each plan's enrollees. Texas calculates report cards separately for each managed care program[3], which reduces differences in the populations and services covered by each program. The MA rating system has a categorical adjustment index that adjusts for contract differences based on the proportion of plan-enrolled beneficiaries that are low income or disabled.

[2] In Pennsylvania, health plans report their performance on required quality measures based on their statewide performance. When the state calculates ratings, it does so regionally so that only plans within a given region compare with each other. This has the effect of allowing the same plan to have different ratings in different regions, even though the underlying data are the same.

[3] Managed care programs in Texas are STAR, STAR + PLUS, STAR Kids, and STAR Health. STAR covers low-income children, pregnant women, and families. STAR+PLUS covers people who have disabilities or are age 65 or older. STAR Kids cover children and adults age 20 and younger who have disabilities. STAR Health covers children in Department of Family and Protect Services conservatorship, children in the Adoption Assistance or Permanency Care Assistance program who are transitioning from STAR Health to STAR or STAR Kids, youth age 21 years and younger with voluntary extended foster care placement agreements, and youth age 20 and younger who are Former Foster Care Children.

C. Uses of the QRS

This section presents themes related to how beneficiaries use the QRSs to select plans, how health plans use them for quality improvement, and how states use them for health plan accountability and oversight.

Use by beneficiaries

Although the QRS was developed primarily for beneficiaries, there is little evidence that beneficiaries use the state rating systems to select plans, and none of the states interviewed track this information or direct their enrollment brokers to point beneficiaries to the QRS. Enrollment brokers and beneficiary advocates in all states suggested that beneficiaries select plans based on providers participating in the network and value-added services when making plan selections. In the case of the federal quality rating systems, another factor driving plan selection may be premiums or cost-sharing.

State Medicaid officials reported that enrollment materials provided to eligible beneficiaries include a copy of the PDF-based QRS. During interviews, however, enrollment brokers in each state shared that they do not use the QRSs when counseling beneficiaries on plan selection nor do they refer beneficiaries to the rating system for more information. All enrollment brokers reported that they have state-approved scripts they use to guide beneficiary discussions, none of which reference the QRS in the state. In addition, enrollment brokers in Michigan and Pennsylvania shared that beneficiaries rarely reference the QRS in their interactions or ask questions about health plan quality. In Ohio, however, state Medicaid officials noted that consumer advocacy groups sometimes use the QRS in their communications and guidance to members.

Most states also provide information in addition to the QRS to facilitate health plan selection. For example, in Pennsylvania, upon qualifying for Medicaid, new beneficiaries receive a welcome packet that contains a comparison chart of all available health plans available in that region, including extra benefits offered by each plan—as well as a copy of the QRS. The Pennsylvania enrollment broker reported beneficiaries referenced that comparison chart more than the QRS in their interactions. In Michigan, the enrollment brokers do not use the QRS when conversing with beneficiaries but can identify the plans that include their existing providers. In Ohio, the QRS on the Medicaid website contains a link to a "find a provider" tool, which health plan representatives felt was useful for beneficiaries to identify the plans that include their existing providers and for selecting a health plan.

State Medicaid officials reported that substantial time and effort go into making the QRS useful for beneficiaries. This includes ensuring that information is presented in plain language at an appropriate reading level and providing guidance on how to interpret health plan performance on the QRS. Most state Medicaid officials noted that they do not track whether beneficiaries enroll in higher-rated plans more frequently, nor do they monitor internet traffic or visits to the QRS platform, which could provide more insight on the utility of the QRS. Several states and the federal quality rating systems use various mechanisms for beneficiaries to test or provide feedback on the QRS, for example, focus groups or a beneficiary advisory committee. However, most states reported that beneficiary input was limited to the layout and presentation of the QRS rather than determining which measures would be most meaningful to beneficiaries in selecting plans.

Use by health plans

State Medicaid officials, CMS officials, and MCO representatives agreed that health plans tend to allocate their quality improvement resources to focus on measures tied to financial or enrollment incentives, rather

than those in the QRS. Although some health plans reported focusing on all quality initiatives equally during interviews, others reported putting more resources behind measures tied to revenue, such as those included in the state's capitation withholds or auto-assignment algorithm. In all five states, the QRS itself does not directly link to financial incentives, but many of the measures used to calculate health plan ratings in the QRS also serve in other payment or incentive programs (see below for more information). Some state officials suggested that plans might prioritize improving their performance on the measures in which they are closer to achieving some threshold that would increase their rating and might not prioritize the measures for which they would need to dramatically improve performance before achieving some financial or enrollment incentive.

In the MA QRS, CMS reported that when it introduced the quality bonus payment, it saw health plans begin to pay more attention to the measures in the rating system. Over time, MA plans have focused their improvement efforts on measures included in the QRS according to CMS officials and health plans. CMS noted that often lower-performing plans in MA sometimes focus on a few priorities or measures, and higher-performing plans target holistic improvement on all aspects of care delivered to Medicare beneficiaries. When asked about the balance of focusing on specific quality measures versus a broader approach to quality improvement, CMS suggests that targeting specific measures for improvement, instead of the entire domain, seems to result in poorer performance overall.

Though the QRS was not designed for marketing purposes, health plans in some states reported using the QRS as part of their marketing materials—particularly if a plan is a high performer compared with its competitors. In MA, health plans are required to include their star rating in their marketing materials.

Use by states to incentivize health plan improvement

States also encourage health plan performance improvement by tying payment to other quality initiatives. State Medicaid officials reported that by aligning measures across multiple initiatives, they intend to signal to health plans the state's priorities for improving beneficiary outcomes. Although none of the state rating systems explicitly tie payment to the QRS ratings, measures tied to financial or enrollment incentives are often the same, or similar, to those used in the QRS. Health plan contracts typically require plan reporting on many quality measures for various purposes, which may be different than those used to calculate ratings in the QRS.

For example, states can use capitation rate withholds to hold plans accountable for a variety of performance standards, including quality, and the measures used in capitation withholds often are the same as those used in the state's QRS. For example, of the roughly 60 measures that make up the Ohio QRS, 16 (or 27 percent) are also used for the capitation withhold. Accordingly, improvement on those measures might result in higher health plan ratings and payments. In other initiatives, plans might be subject to penalties in which performance below a benchmark results in a fine or other financial penalty. In Ohio, of the 61 measures subject to penalties if health plan performance falls below the 25th percentile statewide, 37 are QRS measures as well. In Florida, liquidated damages apply to health plans if their performance falls below the national Medicaid 50th percentile on 24 of the 27 QRS measures (86 percent).

Pay-for-performance programs can also overlap with QRS measures. In Pennsylvania, around a dozen measures are used for both the QRS and the pay-for-performance program, which is worth up to 2 percent of total capitation. Pennsylvania Medicaid officials reported seeing health plan performance improve on

most of the measures included in both the QRS and pay-for-performance program. Michigan and Texas also have pay-for-performance programs that include measures that overlap with the QRS in those states.

Another way states give health plans an incentive to improve quality is through beneficiary automatic assignment algorithms, which assign beneficiaries to health plans if they do not select a plan within a certain period of time after becoming eligible for Medicaid. In Ohio, auto-assignment ties to plan performance on women's health measures, which overlap with the QRS measures in that domain and the state's capitation withhold program. Michigan's auto-assignment algorithm also includes performance on measures that overlap with the QRS and assigns beneficiaries to health plans proportionally based on performance. Beginning in September 2020, Texas changed its auto-assignment algorithm to assign beneficiaries to plans based on a number of criteria including the plan's overall quality rating in the QRS.[4] This change in Texas will represent the strongest link between QRS and auto-assignment among the five states studied.

Use by states for overseeing and monitoring health plans

State Medicaid programs generally do not use plan ratings to identify health plans for additional oversight or monitoring. Instead, states use other initiatives to do so, such as capitation withholds, mandatory performance improvement projects required of each managed care plan (§42 CFR 438.310), corrective action plans, penalties, and procurement processes. While these other initiatives often use similar measures as those in the QRS, the QRS is generally not the mechanism used for oversight. For example, Pennsylvania conducts quarterly review meetings with health plans performing below the 50th percentile in some of the measures used in the state's pay-for-performance program. The pay-for-performance measures and the QRS overlap somewhat, but it is the pay-for-performance program that triggers this oversight review, not health plan's QRS rating. States can also require plans that do not achieve minimum quality scores to develop and implement corrective action plans.

In the MA QRS, plans that consistently perform poorly (an overall rating below 2.5 stars for three consecutive years) receive warning letters and ultimately face termination from the Medicare program. The Marketplace QRS is connected to some mechanisms for accountability, since reporting of the underlying quality measures is a certification requirement for Marketplace QHP issuers to participate in the Marketplace QRS. However, because the Marketplace QHP QRS is a new program, there is not currently a formal connection between the QRS and payment incentives.

Use by states to further health equity

None of the rating systems in the study currently report on measures related to health equity, nor are they the primary vehicle for monitoring health care disparities in the state or federal programs. Although many states reported a desire to use quality reporting to monitor and report on racial and ethnic disparities, many said that they did not have the data to address this topic. Several states, however, shared that they planned new activities in this area. Florida plans to require plans to have their Medicaid health plans stratify selected measures by race and ethnicity for calendar year 2020. Michigan has a current initiative related to reducing disparities in specific areas, including maternity care and well-child visits and plans to focus more on health equity in future updates to its quality reporting requirements. Pennsylvania requires plans to report selected measures stratified by race and ethnicity but does not use those data for public

[4] 2020-21 General Appropriations Act, House Bill 1, 86th Legislature, Regular Session, 2019, Article II, HHSC, Rider 43.

reporting yet. Pennsylvania also plans to include health equity in its pay-for-performance program in the near future.

CMCS shared that during beneficiary testing for the MAC QRS, the topic of reporting health plan performance on measures stratified by race and ethnicity did not come up as a desired element of the QRS; at the time of the interview, it was not leaning toward requiring such stratification in the first iteration of the MAC QRS requirements.

D. State preparation to comply with federal QRS requirements

At the time of the interviews, most state Medicaid officials were familiar with the QRS components of the Medicaid and CHIP managed care regulations, but needed more concrete information, including the mandatory measure list, before making plans to change their QRS. Several states felt confident that their existing rating systems would be well aligned with what they anticipate will be in the final CMS requirements. Representatives from some study states reported participating in CMS's stakeholder engagement activities and reported during interviews that they were confident CMS was considering feasibility when making decisions about the QRS.

> **"I think whatever would be selected by CMS would be done in a very thoughtful way. I'm hoping that a lot of things they look at are the Core Set measures."**
>
> ***State Medicaid official***

State and stakeholder concerns with federal QRS requirements

State and national stakeholders generally agreed that a uniform set of measures in state QRSs was important for monitoring the performance of Medicaid programs across states, but there was not clear consensus on the most appropriate measures for a mandatory set. There was concern that a mandatory set of measures might be difficult to implement because states take different approaches to carving out certain services, such as children's dental care or behavioral health. If, for example, CMCS requires a behavioral health measure in the MAC QRS, states that carve out these services from managed care coverage would be unable to calculate and report the measure. State officials were also concerned that CMCS might require the MAC QRS to rate specialty plans and noted that it would be difficult to implement because most states (except Florida and Texas) do not include specialty plans in their existing QRSs. In response to public comments on the 2018 proposed rule, CMS stated that it intends "to take considerations related to service carve-outs and limited benefit plans into account in development of the proposed MAC QRS-specific rulemaking" (CMS 2020).

Among the five states studied, Texas expressed the most concern about what measures CMS might require. Texas' QRS uses different measures for each of its Medicaid programs. In a public comment, state Medicaid officials stated that they intentionally selected these measures because they are relevant to each of the populations served by these programs, and state officials were concerned adding measures to comply with CMS requirements might dilute the relevance of their rating systems (Texas Health and Human Services Commission 2019).

Alignment between MAC QRS and other federal rating systems

Alignment between MAC QRS and other federal reporting programs is a high priority for states and CMS in order to reduce reporting burden across programs and providers. But, as with opinions on which measures to include in the MAC QRS, interviewees differed as to which programs they thought the MAC

QRS should most closely align. In the 2020 final rule, CMCS signaled a desire to closely align the MAC QRS with the Medicaid and CHIP Scorecard initiative. States expressed different opinions on which elements of other programs the MAC QRS should align with—whether it is only the measures included, or other elements such as the rating domains, the platform used, or visual design.

Representatives from national stakeholder groups emphasized the importance of aligning the mandatory minimum measures in the MAC QRS with other national reporting programs, highlighting the Medicaid and CHIP Core Sets and HEDIS reporting. They emphasized that states should maintain the flexibility to add state-specific measures that reflect state priorities but said that most measures should be consistent across state rating systems. In the 2020 final rule, CMCS noted that "states will continue to have flexibility to add measures for services, programs and populations that are important to each state, should the full MAC QRS measure set not include specific measures important to a particular state for its quality improvement goals" (CMS 2020).

Anticipated state technical assistance needs

Unlike those states that have experience implementing a QRS on a voluntary basis, states that do not currently have a QRS will have to create systems and processes to comply with federal MAC QRS requirements and are likely to require technical assistance. In an interview, representatives from CMCS emphasized that they are designing a system that is feasible for every state—from those with no existing quality reporting at all to states with mature rating systems such as those in this study. Representatives from the federal quality rating systems reported that they offer significant technical assistance to health plans, at the initial implementation of the rating system and in an ongoing manner. This assistance generally took the form of a helpdesk email box, webinars, and written guidance and frequently-asked-question documents.

"There is a broad array of readiness. A QRS for a state like California is a whole other thing than for Rhode Island. And different challenges come into play."

CMCS official

EQRO stakeholders reported that they would be well positioned to help states implement a QRS. As required by the 2016 final rule, CMCS plans to develop a protocol for an external quality review (EQR) plan rating optional activity that would guide the EQROs in their efforts to help states comply with the final requirements. States that choose to deploy this optional plan rating activity and conduct it consistent with the protocol could be eligible for enhanced federal financial participation matching rates, thereby facilitating the financial viability of meeting the QRS requirements (CMS 2016).

E. Impact of quality rating systems

The effect that QRSs had on health plan performance and beneficiary enrollment varied by state. Both states and federal quality rating systems reported experiencing a mix of improvement and stagnation of health plan performance over time, and most states reported difficulty tracking how beneficiaries use the rating systems. Several of the states also highlighted challenges unique to the COVID-19 pandemic and how it would influence quality reporting and state rating systems, as detailed in the call-out box in this section.

Health plan performance over time

The states and federal quality rating systems varied in the extent to which they tracked and reported health plan performance over time. Of the five states studied, four (Florida, Michigan, Ohio, and Pennsylvania) reported tracking plan performance over time.[5] Some shared the trends in a publicly available document available on their state Medicaid website. None of the states, however, reported plan performance over time within the QRS platform.

Changes in plan performance varied across these states. Florida and Michigan both reported some areas where they believed performance improved. Pennsylvania reported some improvement on individual measures but also acknowledged that performance gains typically disappear when the state's quality improvement priorities move on to new focus areas or because of turnover among health plans in the market. Ohio expressed disappointment with its results, indicating that performance on some key measures (for example, postpartum visits) remained the same for more than 20 years.

The MA QRS tracks performance over time and includes measures related to plan performance over time in the ratings. Plans with consistently high or low performance on the MA QRS receive a high-performing indicator or low-performing indicator. CMS officials working on the MA QRS reported some improvements in MA plan performance over time. The Marketplace QHP QRS is too new to report longitudinal plan performance.

Impact of COVID-19 on quality reporting

- **The National Committee for Quality Assurance issued guidance for HEDIS measures** that allow plans to report 2019 rates on hybrid measures that require medical records that have been inaccessible during the pandemic. Some states, including Florida, Michigan, and Texas, expressed concern that this flexibility could create challenges for state rating systems if plans report rates from different time periods. At the time of interviews, **states had not firmly decided whether or how to adjust their rating methodology to account for challenges** as a result of COVID-19.
- **COVID-19 has impacted different areas of the country at different time periods and with different severities.** This might result in COVID-19 impacting the benchmarked performance differently depending on the QRS methodology in different rating systems.

Beneficiary enrollment

Because states do not systematically track how beneficiaries use the QRS, it is difficult to quantify the impact of the rating systems on beneficiaries' behavior. Although the federal quality rating systems collect information on enrollment by plan rating, most states were not tracking beneficiary enrollment in highly rated plans, nor did they report anecdotal movement of beneficiaries from poorly rated plans to more highly rated ones. State Medicaid officials explained that tracking beneficiary movement and enrollment would be difficult because most states use domain-level ratings. Given how different

[5] The remaining state, Texas, does not report star-ratings over time because its methodology prevents equivalent year-to-year comparisons.

beneficiaries prioritize different domains according to their needs, states reported that it is challenging to isolate one domain and track enrollment.

According to Texas data, in 2020 , about 16 percent of Medicaid managed care members were enrolled in a 5-star plan; 30 percent of Medicaid managed care members were enrolled in a 4-star plan; 44 percent of Medicaid managed care members were enrolled in a 3-star plan; 9 percent of Medicaid managed care members were enrolled in a 2-star plan; and 1 percent of Medicaid managed care members were enrolled in a 1-star plan. The MA program also tracks this information. About 81 percent of beneficiaries are currently in MA plans with drug coverage that have a 4- or 5-star rating for 2020 (Jacobson et al. 2020).

Section 5. Conclusion

This report documents the use of QRSs in five state Medicaid managed care programs, and two federal health programs, to inform MACPAC's ongoing efforts to assess and ensure quality care provided to Medicaid beneficiaries. This study found that the primary goal of state Medicaid managed care QRSs is to inform beneficiaries' choices, and the systems are designed to help beneficiaries understand performance differences in the health plans available to them. Design decisions such as the benchmarking approach, the rating scale, and the format of the QRSs are intended to support this primary policy objective. The study did not find any evidence that Medicaid beneficiaries actually use QRSs to select a health plan, however, as none of the states included in the study track this.

A secondary goal of the QRSs is to improve health plan performance, and most study states use many of the same quality measures in the QRS that are used in payment and quality improvement initiatives. States, however, do not directly use the QRS to hold poor performing plans accountable, unlike the MA QRS, which sends letters to poorly performing plans and can ultimately terminate them from the program if they receive an overall rating of 2.5 stars or lower for three consecutive years. States use other levers to sanction plans with low quality scores, such as capitation withholds, mandatory performance improvement projects, corrective action plans, penalties, and procurement processes.

Finally, the study assessed states' preparedness to comply with CMS requirements related to a MAC QRS. Representatives from the states included in the study, as well as those from national organizations, generally support greater alignment across quality reporting programs. Representatives from the states emphasized their desire for flexibility in the MAC QRS requirements to allow states to include measures that reflect the specific needs and priorities of populations and services covered by Medicaid managed care programs in each state. The findings of this report, and the detailed profiles of the state and federal quality rating systems contained in the appendices, can inform CMS and state officials as they design and implement a MAC QRS.

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Appendix A:
Florida QRS Profile

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FLORIDA

Florida Medicaid uses a five-star Quality Rating System (QRS) for their Medicaid managed care organizations (MCOs). The QRS calculates star ratings for managed medical assistance (MMA) plans, which cover physical health services, as well as behavioral health services and chronic disease management. Some of these plans also cover long-term care services. Florida Medicaid also offers dental-only plans, which are not rated in the QRS. In this profile, we focus on the QRS for MMA plans.

Overview of the managed care environment	
Market overview	• **Total enrollment in Medicaid managed care:** As of July 2020, over 3.2 million Medicaid beneficiaries were enrolled in Florida's managed care programs; this represents 78 percent of Medicaid beneficiaries.[a] • **Managed care organizations:** Florida has 15 MCOs operating in the state. These MCOs may offer multiple plans.[b] – **Market share:** The largest MCOs by market share include Centene (17%), Anthem (15%), Humana (15.6%), UnitedHealth Group (8%), and WellCare (28%)—which are all for-profit firms. In addition, two national nonprofit firms, Magellan Health and Molina, together make up about 3.7 percent of the market share. All others make up the remaining share of the market.[a,c] – **Plan performance**: Florida does not report enrollment based on a MCO's star rating.[a] • **Geographic service area**: Plans are contracted to provide services state-wide or at the regional level. There are 11 regional service areas.[d] • **Types of plans offered:** Comprehensive MCOs (7 plans) offer managed medical assistance and long-term care (LTC); LTC Plus (1 plan), which offers medical assistance and LTC only to Medicaid recipients in need of LTC care, managed medical assistance only plans (7 plans), and dental plans (3 plans). The comprehensive and managed medical assistance only plans include standard and specialty plans.[a]
Populations covered in the QRS	• Florida's QRS calculates ratings for both standard managed medical assistance and specialty managed medical assistance plans. Specialty plans are identified with an icon on the QRS to indicate that they serve different populations.[b]
State-level MCO or plan-level quality initiatives	• **Overall strategy:** The state identified five priority areas in the managed care quality strategy:[f] – Improved health outcomes – Simplified and streamlined service delivery to promote efficient, timely, appropriate use of health services – Support for person and family-centered care (QRS is an initiative supporting this priority area.) – Greater transparency and accountability to promote cost effectiveness and efficient administration (QRS is an initiative supporting this priority area.) – Improved care coordination through performance monitoring and communication • **Performance improvement projects:** There are ongoing PIPs on reducing adverse birth outcomes, reducing potentially preventable hospital events, improving access to transportation, and mental health. Some of the mental health metrics are included in the plans' PIPs and the QRS.[a]

Quality Rating System design	
Link to QRS	The Florida Medicaid Health Plan Report Card can be accessed here: https://www.floridahealthfinder.gov/HealthPlans/Search.aspx?p=5
History and evolution of QRS	• **History of the QRS:** The report card was first published in Fall 2015, with data from calendar year 2014. The report cards were included in the Special Terms and Conditions for the 1115 Managed Medical Assistance Waiver.[a,h] • **Evolution of the QRS:** Overall, the measures have remained the same year to year, with the exception of the removal of some measures if they are retired by the measure steward.[h]
Rating scales and benchmarks	• **Rating levels:** Ratings used in the QRS are reported at the domain level; there is no overall summary rating. Star ratings are only reported for quality of care indicators, not member satisfaction scores.[i] • **Rating scale:** Star ratings for health plans are calculated using a five-category scale. See the section on scoring methodology and rules for more information.[i] – 1 star: Very Poor (worse than 90% of all health plans' scores in Medicaid) – 2 stars: Poor (better than at least 10% of all health plans' scores in Medicaid) – 3 stars: Fair (better than at least 25% of all health plans' scores in Medicaid) – 4 stars: Good (better than at least 40% of all health plans' scores in Medicaid) – 5 stars: Best (at or above 50% of all Medicaid health plans' scores in Medicaid) • **Rating benchmarks:** Ratings are calculated by comparing the plan's performance on individual HEDIS measures against the HEDIS national means and percentiles of all health plans in Medicaid.[a, i]
Quality measures used in the QRS	• **Domains:** The report card is divided into the following domains: [f] – Pregnancy-Related Care (2 HEDIS measures) – Keeping Kids Healthy (8 HEDIS measures) – Keeping Adults Healthy (5 HEDIS measures) – Living with Illness (6 HEDIS measures) – Behavioral Health Care (6 HEDIS measures) • **Measures:** The QRS uses 27 total measures, which are a subset of the 40 quality measures plans are required to report to the state each year. Of the 27 QRS measures, 24 are also Core Set measures. Please see Table A.1 for a detailed list of all of the measures included in Florida's QRS.[b,f]

Quality Rating System design	
Scoring methodology and rules	• **Responsibility for calculating ratings:** Florida Medicaid requires that all statewide Medicaid managed care plans report HEDIS performance measures that are audited and certified. Managed care plans are required to contract with software vendors that are certified through the NCQA Measure Certification program, which validates the data reporting.[a,f] Florida Medicaid calculates plan-level ratings for display on the QRS.[h] • **Methodology:** For each measure in the QRS, the performance scores are divided into deciles. The rates determine the number of stars for that particular measure, as described above in the rating scale section. For example, if a plan's score for Adolescent Well-Care Visits is 66 percent, and the 50th percentile rate is 63 percent, then the plan would have a rating of 5 stars for this measure because its rate is above the 50th percentile rate. Scoring rules are the same for all quality measures; none are weighted differently. Scores are not adjusted to reflect the population served or the geographic service area.[f,h]
Rating display and formats	• **Rating display:** Florida Medicaid hosts a web-based platform where users have the option to view the domain-level ratings, or they can drill down into the measures contained in each domain and toggle between ratings and scores on the measures within those domains. The QRS indicates if a plan was unable to report valid rates for less than half of the performance measures in a particular domain by displaying "N/A." Users can see the ratings for all plans in the state or only choose to see ratings for plans that are offered in their county.[c] • **Format of QRS:** Ratings are presented in a web-based platform.[c] • **Plan changes over time**: There is no indication of change in plan performance over time in the QRS.[b,j] • **New plans:** These plans that are too new to rate receive an "N/R" rating. Plans have a year between when they begin providing services and when they report performance measures and receive a rating.[b] • **Frequency of rating updates**: The data are reported by the managed care plans to Florida Medicaid on July 1 of every year on the services delivered in the previous calendar year (for example, calendar year 2019 data is reported on July 1, 2020). Florida Medicaid calculates the ratings and publishes the report card in the fall of every year.[a,f] • **Other indicators**: The QRS also indicates if a plan only serves people with certain diagnoses or conditions by displaying an asterisk. These specialty plans are displayed with the standard plans; therefore, these plans may perform differently because the scoring rules are not risk adjusted for specialty plans or populations.[a,b]
Stakeholder engagement in QRS development and updates	Regular meetings and communications with the health plans, enrollees, advocacy groups, other agencies, and other stakeholders support these partnerships. Stakeholders identify areas in need of improvement, as well as the corresponding performance metrics and standards that may be targeted for inclusion in health plan contract requirements.[f,h]

Quality Ratings Systems uses	
Informing beneficiary choice	• The QRS platform includes links to a number of other consumer resources, such as provider look ups, customer service telephone numbers, the number of beneficiaries in each plan, and consumer guides.[b]
Incentivizing plan performance	• **Auto-assignment:** The auto-assignment algorithm is not tied to any quality performance measures. The state's auto-assignment methodology prioritizes network capacity, continuity of care (for beneficiaries who have been previously enrolled), and geographic accessibility of PCPs to the beneficiary's residence.[f,k,l] • **Capitation withhold (achieved savings rebate):** Florida has a 1 percent achieved savings rebate that is distributed to MCOs that meet or exceed quality metrics on a subset of QRS measures. To be eligible for this rebate, plans must achieve performance measure rates at or above the 75th percentile for five of the ten performance measures in the subset, with none of the rates below the 50th percentile. See Table A.1 for full list measures eligible for the withhold.[a,m] • **Liquidated damages**: Florida Medicaid may impose liquidated damages for performance measures if the plan fails to perform at the level of the state's expected minimum standards. The plan's performance measure rates are compared to the NCQA HEDIS National Means and Percentiles for Medicaid plans. For each measure where the plan's rate falls below the 50th percentile, the plan may receive liquidated damages—which will be calculated based on the number of members eligible for the measure who did not receive the service being measured up to the 50th percentile rate. The amount of liquidated damages will vary depending on the tier that measure falls under (there are a total of three tiers). Florida Medicaid may reduce the liquidated damage amount when the rate for a performance measure has improved three percentage points or more compared to the previous reporting period, and the rate for the performance measure is between the 40th and 50th percentiles. See Table A.1 for a full list measures subject to liquidated damages.[a,h,j,m]
Conducting plan oversight	• **Oversight mechanisms:** Florida Medicaid may sanction plans for failure to achieve minimum scores on HEDIS performance measures after the first year of poor performance, such as a monetary sanction of up to $10,000 for each performance measure group where the group score is below three. Plans may also be required to complete a Performance Measure Action Plan after the first year of poor performance. Plans must achieve a CHCUP screening rate of at least 80 percent for those members who are continuously enrolled in the plan for at least 8 months during the federal fiscal year. If a plan does not meet this rate, they may be required to submit a corrective action plan and may be assessed for liquidated damages.[f,m]

[a] Florida Agency for Health Care Administration (AHCA). 2020. Florida Medicaid: Revisions to state profile by Rachel Lacroix (Administrator of Performance Measurement and Quality Review, Bureau of Medicaid Quality), September 30, 2020 and February 2, 2021.

[b] Florida Agency for Health Care Administration (AHCA). 2019. Health plan information. https://www.floridahealthfinder.gov/HealthPlans/Default.aspx.

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[i] Florida Agency for Health Care Administration (AHCA). 2019. Florida Health Plan consumer information: methods and data sources. https://www.floridahealthfinder.gov/HealthPlans/Methods.aspx.

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[l] Florida Agency for Health Care Administration (AHCA). 2019. Florida Medicaid managed care auto-assignment methodology. Tallahassee, FL: Florida AHCA. https://ahca.myflorida.com/Medicaid/recent_presentations/2019/Auto-Assignment_Report_100119_Final.pdf.

[m] Florida Agency for Health Care Administration (AHCA). 2020. Managed Medical Assistance Program Contract: Attachment II. Tallahassee, FL: Florida AHCA. https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2020-07-01/Exhibit_II_A_MMA-2020-07-01.pdf.

CHCUP = child health check-up; HEDIS = Healthcare Effectiveness Data and Information Set; LTC = long-term care; MCO = managed care organization; MMA = managed medical assistance; MPIP = MMA Physician Incentive Program; NCQA = National Committee for Quality Assurance; OB/GYNs = obstetricians/gynecologists; PCMH = patient-centered medical home; PCSP = Patient-Centered Specialty Practice; PCP = primary care provider; PIP = performance improvement project; QRS = Quality Rating System.

Table A.1. Measures reported by Florida Medicaid health plans by quality initiative as of August 2020

Measure	Measure data source	QRS[a]	FFY 2020 Child or Adult Core Set measure[b]	Withhold[c]	Liquidated damages[c]
Pregnancy-Related Care					
Postpartum Care	HEDIS	X	X		X
Timeliness of Prenatal Care	HEDIS	X	X		X
Keeping Kids Healthy					
Adolescent Well-Care Visits	HEDIS	X	X		X
Childhood Immunization Status—Combo 3	HEDIS	X	X		X
Children & Adolescents' Access to PCPs, Ages 12 Months to 19 Years	HEDIS	X	X		X
Chlamydia Screening in Women, Ages 16 to 20 Years	HEDIS	X	X		
Immunizations for Adolescents —Combo 1	HEDIS	X	X		X
Lead Screening in Children	HEDIS	X			X
Well-Child Visits, First Fifteen Months of Life (Six or More Visits)	HEDIS	X	X		X
Well-Child Visits, Ages 3 to 6 Years	HEDIS	X	X		X
Keeping Adults Healthy					
Adult BMI Assessment	HEDIS	X	X		X
Adults' Access to Preventive Health Services	HEDIS	X			X
Breast Cancer Screening	HEDIS	X	X		X
Cervical Cancer Screening	HEDIS	X	X		X
Chlamydia Screening in Women, Ages 21 to 24 Years	HEDIS	X	X		
Chlamydia Screening in Women (combined age groups)	HEDIS				X
Living With Illness					
Asthma Medication Ratio	HEDIS		X	X	X
Controlling High Blood Pressure	HEDIS	X	X	X	X
Diabetes Care: HbA1c Testing	HEDIS	X			X
Diabetes Care: HbA1c—Good Control (<8%)	HEDIS	X		X	X
Diabetes Care: Eye Exam	HEDIS	X			X
Diabetes Care: Nephropathy	HEDIS	X			X
Human Immunodeficiency Virus (HIV) Viral Load Suppression	HRSA	X	X	X	X

Measure	Measure data source	QRS[a]	FFY 2020 Child or Adult Core Set measure[b]	Withhold[c]	Liquidated damages[c]
Behavioral Health Care					
Antidepressant Medication Management —Acute	HEDIS	X	X	X	X
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	HEDIS	X	X	X	X
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence, 7 day—Total	HEDIS	X	X	X	X
Follow-up After Emergency Department Visit for Mental Illness	HEDIS	X	X	X	X
Follow-up After Hospitalization for Mental Illness, 7 Day & 30 Day	HEDIS	X	X	X (7 Day only)	
Follow-up Care for Children for Prescribed ADHD Medications, Initiation Phase	HEDIS	X			X
Initiation and Engagement of Alcohol and Other drug Dependence Treatment, Initiation—Total	HEDIS		X	X	X
Member Satisfaction					
Percentage of respondents reporting it is usually or always easy to get needed care (vs. sometimes or never)	CAHPS	X	X		
Percentage of respondents reporting it is usually or always easy to get care quickly (vs. sometimes or never)	CAHPS	X	X		
Percentage of respondents reporting doctors usually or always communicate well (vs. sometimes or never)	CAHPS	X	X		
Percentage of respondents reporting they usually or always get the help/information needed from their plan's customer service staff (vs. sometimes or never)	CAHPS	X	X		
Percentage of respondents reporting plans usually or always process claims quickly and correctly (vs. never or sometimes)	CAHPS		X		
Percentage of respondents rating their plan an 8, 9, or 10 on a scale of 0 (worst) to 10 (best)	CAHPS	X	X		
Percentage of respondents rating the number of doctors to choose from as excellent or very good (vs. good, fair, or poor)	CAHPS		X		
Percentage of respondents reporting they definitely or probably would recommend their health plan to family and friends	CAHPS		X		
Percentage of respondents reporting they definitely or probably would select their current plan again	CAHPS		X		
Percentage of respondents who reported there is shared decision making between the provider and respondent	CAHPS		X		

[a] Florida Agency for Health Care Administration (AHCA). 2017. Comprehensive Quality Strategy Report. Tallahassee, FL: Florida AHCA. https://ahca.myflorida.com/medicaid/Policy_and_Quality/Quality/docs/CQS_Final_Draft_2017_03-02-2017.pdf.

[b] Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services.2020. Adult and Child Health Care Quality Measures. https://www.medicaid.gov/medicaid/quality-of-care/quality-of-care-performance-measurement/adult-and-child-health-care-quality-measures/index.html.

[c] Florida Agenda for Health Care Administration (AHCA). 2020. Managed Medical Assistance Program Contract: Attachment II. Tallahassee, FL: Florida AHCA. https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2020-07-01/Exhibit_II_A_MMA-2020-07-01.pdf.

ADHD = attention deficit hyperactivity disorder; BMI = body mass index; CAHPS = Consumer Assessment of Healthcare Providers and Systems; HbA1c hemoglobin A1C; HEDIS = Healthcare Effectiveness Data and Information Set; HIV = human immunodeficiency virus; HRSA = Health Resources and Services Administration; PCP = primary care provider; QRS = Quality Rating System.

Appendix B:
Michigan QRS Profile

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MICHIGAN

Michigan Medicaid uses a three category "apple" rating scale for their state's Quality Rating System (QRS) for their Medicaid managed care organizations. Michigan Medicaid offers comprehensive managed care plans, as well as plans covering dental services or managed long-term services and supports. In this profile, we focus on comprehensive managed care plans, which are the only plan types that receive a rating in Michigan's QRS.

Overview of the managed care environment	
Market overview	• **Total enrollment in Medicaid managed care:** As of July 2017, approximately 2.4 million Medicaid beneficiaries were enrolled in Michigan's managed care programs; this represents 52 percent of Michigan's Medicaid beneficiaries.[a,b] • **Managed care organizations:** Michigan has 10 MCOs operating in the state.[c] – **Market share:** The largest MCOs by market share include Meridian (27%), Molina (19%), UnitedHealthcare (14%), and Blue Cross Complete of Michigan (12%)—which are all for-profit firms. In addition, the market share includes one state-level nonprofit, McLaren Health Care (11%). – **Plan performance**: About 4 percent of enrollees are in plans that receive a below average overall quality rating (two apples); 44 percent of enrollees are in plans that receive an average overall quality rating (three apples); and 52 percent of enrollees are in plans that receive an above average overall quality rating (four apples). • **Geographic service area:** Plans are contracted to provide services at the county- and regional-level. There are 10 regional service areas.[c,d] • **Types of plans offered:** Comprehensive MCO (10 plans), MLTSS-only (20 plans), and dental-only (2plan).[c]
Populations covered in the QRS	• The QRS only rates comprehensive MCOs and does not include specialty plans.[d]
State-level MCO or plan-level quality initiatives	• **Overall strategy**: The Michigan quality strategy is aligned with the National Medicaid Quality Strategy and prioritizes (1) health equity; (2) quality, safety, and coordination of care delivered to special populations; (3) enhanced health delivery models; (4) payment transformation; (5) patient and community engagement; and (6) effective population management to improve prevention and treatment of care for leading causes of mortality. The QRS is one component of the state's approach to monitoring plan performance.[e] • **Capitation withhold:** Michigan Medicaid withholds 1 percent of the approved capitation for each contracted MCO in a Performance Bonus Pool used to award the MCO's performance. See the section on incentivizing plan performance for more information.[f,o] • **Overview of plan-level quality initiatives**: In alignment with its quality strategy, Michigan Medicaid has the following quality initiatives for MCOs:[g] – Performance Monitoring Standards, which focus on monitoring MCO performance in the areas of quality, access, customer service, and reporting – Emergency Department Utilization fiscal year 2018 to fiscal year 2020 Focus Bonus, which helps MCOs develop an in-depth understanding of ED utilization in their MCO population and implement interventions that address the causes of ED utilization

Quality Rating System design	
Link to QRS	The Michigan Medicaid Report Card can be accessed here: https://www.michigan.gov/documents/QualityCheckupJan03_59423_7.pdf
History and evolution of QRS	• **History of the QRS:** The Michigan Medicaid Report Card was first implemented in 2003. The EQRO and Michigan Medicaid were involved in the initial development. Consumers or beneficiary advocates were not involved in the development.[o] • **Evolution of the QRS:** Michigan did not initially have an overall rating; it was added in the most recent publication (January 2020).[o] The most recent methodology includes subcategories within each domain that groups similar measures. This addition aims to improve health plans' ability to implement targeted quality improvement efforts.
Rating scales and benchmarks	• **Rating levels:** Ratings for each MCO are reported at the domain level and include an overall summary rating.[h] • **Rating scale:** The QRS uses a three-level rating system[h] – 2 Apples—Plan performance below statewide average – 3 Apples—Plan performance comparable to statewide average – 4 Apples—Plan performance above statewide average • **Rating benchmarks:** Apple ratings are calculated by comparing one MCO's scores against the average of all MCOs in the state.[h]
Quality measures used in the QRS	• **Domains:** QRS measures are divided into the following domains:[e] – Doctors Communication and Service (9 CAHPS measures) – Getting Care (4 CAHPS measures and 7 HEDIS measures) – Keeping Kids Healthy (10 HEDIS measures) – Living with Illness (7 HEDIS measures) – Taking Care of Women (5 HEDIS measures) – Overall Rating (includes all measures as well as 4 additional CAHPS measures) • **Measures:** The QRS uses 25 total measures. All quality-of-care indicators are HEDIS measures, and member satisfaction measures are derived from CAHPS surveys.[k–m] These 25 measures (46 rates) are a subset of several quality measures that health plans are required to report to the state each year. Of the 25 QRS measures, 20 are also Core Set measures.[i,j] See Table B.1 for a list of quality initiative measures reported by MCOs to Michigan Medicaid.

Quality Rating System design	
Scoring methodology and rules	• **Responsibility for calculating ratings:** Michigan's EQRO reviews the quality measure data and calculates the ratings.[e, o] • **Methodology:** – Plans are assigned ratings within each domain based on comparisons to the statewide average. To derive a domain rating, all the rates within a domain are standardized to have a mean of 0 and standard deviation of 1; this ensures that measures with different scales do not disproportionately impact the category rating. For each measure, a standardized score above 0 is above the statewide average; a score below 0 is below the statewide average; and a score of 0 is equal to the statewide average for that measure. To calculate an overall domain score, the standardized scores are summed for every measure in the category, weighted by the inverse of the number of indicators included for each measure (for example, the Comprehensive Diabetes Care measure has five indicators, so each indicator receives a weight of 1/5). There are exceptions to the weighting, where each indicator receives a weight of 1 for areas of high importance (for example, the Prenatal and Postpartum Care indicators each receive a weight of 1 because that is a focus area for the state). For each plan, a pooled variance is calculated based on the variance for each indicator, and the pooled variance is used to calculate a 95 percent confidence interval around the category rating. – Ratings are currently not risk adjusted to reflect differences in enrollees or geographic service area.[o] – The 95 percent confidence interval is used to determine if the health plan's domain score is significantly above or below the Michigan statewide average according to the rating scale above.
Rating display and formats	• **Rating display:** The report card has an apple rating for each domain and an overall rating for each MCO. It provides a brief description of each domain and indicates whether the MCO has NCQA and Utilization Review Accreditation Commission accreditation.[h] • **Format of QRS:** Michigan Medicaid uses a PDF-based report card.[h] • **Plan changes over time**: Michigan Medicaid conducts a year-to-year analysis of plan performance for internal review, but this information is not included in the consumer guide. • **New plans:** New plans are scored once the plan is able to report the HEDIS and CAHPS measures included in the QRS. If a health plan is too new to calculate ratings, then the health plan would not be included in the analysis. The QRS would indicate that the health plan was available but did not have enough data for ratings. • **Data issues:** If a health plan has a small denominator (that is, less than 30 for HEDIS measures and less than 100 for CAHPS measures), then the health plan would receive the average rate across all health plans for that measure. If a health plan did not report a rate or received a biased rate audit designation, then the health plan receives the lowest rate across all health plans for that measure. If more than half the plans had small denominators, received a biased rate audit designation, or did not report on a measure, then that measure is completely removed from the QRS analysis. • **Frequency of rating updates:** The Michigan QRS is updated annually using HEDIS and CAHPS data that are submitted to NCQA each June. For example, the QRS released in January 2020 used HEDIS 2019 (that is, January 1, 2018–December 31, 2018) and 2019 CAHPS (that is, survey administered in Spring 2019 asking about the member's experience in the last six months) data.

Quality Rating System design	
Stakeholder engagement in QRS development and updates	• Annually, alternative QRS methodologies are developed based on feedback/questions received from the health plans. Health plans then have the opportunity to review the alternative methodology results and provide feedback on the methodology used for the QRS.[o,p] • The QRS measures are revisited annually based on changes to the technical specifications (for example, when measures are retired), and the measures reported by the health plans.[o,p]
Quality Ratings Systems uses	
Informing beneficiary choice	• The QRS includes a link to the Michigan Medicaid website and a beneficiary enrollment telephone number, as well as separate telephone numbers for Spanish and Arabic-speaking beneficiaries. It also includes a list of medical services covered by Michigan Medicaid.[h] • Beneficiaries also have access to resources on the Michigan Medicaid website, including an aggregate report of Michigan performance on HEDIS measures and a report showing the distribution of enrollees in plans by age and gender.[n]
Incentivizing plan performance -	• **Auto-assignment:** Michigan Medicaid will automatically assign a larger proportion of beneficiaries to the plans with the highest scores on the measures used in Michigan's Performance Monitoring Standards, which include several HEDIS measures included in the QRS domains (see Table B.1 for measures), as well as data on race and ethnicity. For example, auto-assignment in the Detroit area specifically prioritizes access to care among African Americans. The purpose of this is to incentivize plans to eliminate racial disparities in access to care in the state. In August 2020, about 35 percent of beneficiaries in Medicaid (excluding CHIP and other specialty/carved out plans) were auto assigned.[e,o,q] • **Capitation withhold:** Michigan Medicaid's has a 1 percent capitation withhold that is aligned with quality measures in the QRS. Plans are incentivized to implement quality strategies based on the domain areas, since their performance on the measures affects their capitation withhold.[f,o] • **Pay-for-performance:** Michigan Medicaid has several different pay-for-performance programs for the state's MCOs. These programs include a pilot program focused on housing stability, a program targeting improvements in maternal and child health outcomes, a program focused on the Medicaid expansion population, and the use of alternative payment models. Payment for these programs is determined using a points-based system, as outlined in the managed care contracts. Many of the measures used for these programs overlap with the QRS. See Table B.1 for measures.[e ,f]
Conducting plan oversight	• **Demographic information:** Michigan requires a subset of HEDIS measures, stratified by race/ethnicity, as part of the state's focus on health equity. MCOs are also required to report two HEDIS measures on MCO Diversity:[k] – Race/Ethnicity Diversity of Membership – Language Diversity of Membership—Spoken Language Preferred for Health Care, Preferred Language for Written Materials, and Other Language Needs • **Oversight mechanisms:** The state does not currently use the QRS for any plan oversight purposes.[o]

[a] Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020. Medicaid managed care enrollment report: 2018 managed care enrollment by program and population (all). https://data.medicaid.gov/Enrollment/2018-Managed-Care-Enrollment-by-Program-and-Popula/a9yv-frjb/data.

[b] Medicaid and CHIP Payment and Access Commission (MACPAC). 2019. *MACStats: Medicaid and CHIP data book*. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2020/01/MACStats-Medicaid-and-CHIP-Data-Book-December-2019.pdf.

[c] Health Management Associates (HMA). 2020. HMA Managed Medicaid Opportunity Assessment for Michigan.

[d] Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018. Medicaid managed care enrollment report: 2018 managed care enrollment by program and plan. https://data.medicaid.gov/Enrollment/2018-Managed-Care-Enrollment-by-Program-and-Plan/5gyf-8cgz/data.

[e] Michigan Department of Health and Human Services (MDHHS). 2015. Michigan Medicaid quality assessment and improvement strategy 2015. Lansing, MI: MDHHS. https://www.michigan.gov/documents/mdhhs/Quality_Strategy_2015_FINAL_for_CMS_112515_657260_7.pdf.

[f] Michigan Department of Health and Human Services (MDHHS). 2020. Comprehensive health care program for the Michigan Department of Health and Human Services. https://www.michigan.gov/documents/contract_7696_7.pdf.

[g] Michigan Department of Health and Human Services (MDHHS) and Health Services Advisory Group, Inc. 2020. SFY 2018-2019 External quality review technical report for Medicaid health plans. https://www.michigan.gov/documents/mdhhs/MI2018-19_MHP_EQR-TR_F1_689146_7.pdf.

[h] Michigan Department of Health and Human Services (MDHHS). 2020. A guide to Michigan Medicaid health plans. https://www.michigan.gov/documents/QualityCheckupJan03_59423_7.pdf.

[i] Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019. 2020 Core Set of Child Health Care Quality Measures for Medicaid (Child Core Set). https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-child-core-set.pdf.

[j] Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019. 2020 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set). https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-adult-core-set.pdf.

[k] Michigan Department of Health and Human Services (MDHHS) and Health Services Advisory Group, Inc. 2019. 2019 HEDIS aggregate report for Michigan Medicaid. Lansing, MI: MDHHS. https://www.michigan.gov/documents/mdhhs/MI2019_HEDIS-Aggregate_Report_rev_669299_7.pdf.

[l] Michigan Department of Health and Human Services (MDHHS) and Health Services Advisory Group, Inc. 2019. 2019 Michigan Department of Health and Human Services: Child Medicaid health plan CAHPS report. Lansing, MI: MDHHS. https://www.michigan.gov/documents/mdhhs/2019_MI_CAHPS_Child_Medicaid_Report_Final_666000_7.pdf.

[m] Michigan Department of Health and Human Services (MDHHS) and Health Services Advisory Group. 2019 Michigan Department of Health and Human Services: Adult Medicaid health plan CAHPS report. Lansing, MI: MDHHS. https://www.michigan.gov/documents/mdhhs/2019_MI_CAHPS_Adult_Medicaid_Report_Final_666343_7.pdf.

[n] Michigan Department of Health and Human Services (MDHHS). 2020. Medicaid reports. https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860_78446_78576---,00.html.

[o] Michigan Department of Community Health. 2020. Interview conducted by Mathematica and the Medicaid and CHIP Payment and Access Commission (MACPAC), August 28.

[p] Blue Cross of Michigan. 2020. Interview conducted by Mathematica and the Medicaid and CHIP Payment and Access Commission (MACPAC), October 28.

[q] Michigan Department of Health and Human Services (MDHHS). 2020. Michigan Medicaid enrollment report. August 2020. https://www.michigan.gov/documents/mdhhs/JE02_082020_701693_7.pdf

CAHPS = Consumer Assessment of Healthcare Providers and Systems; CHIP = Children's Health Insurance Program; ED = emergency department; EQRO = External Quality Review Organization; HEDIS = Healthcare Effectiveness Data and Information Set; MCO = managed care organization; MLTSS = Managed Long-Term Services and Supports; NCQA = National Committee for Quality Assurance; PDF = portable document format; QRS = Quality Rating System.

Table B.1. Alignment of Michigan QRS measures with other quality initiatives as of August 2020

Measure[a]	Measure steward/data source	QRS[b]	FFY 2020 Child or Adult Core Set measure[c]	Pay-for-performance[b,d]	Auto-assignment[b]
Customer Service (2 rates) – Child Medicaid – Adult Medicaid	NCQA - CAHPS	X		X	
Getting Care Quickly (2 rates) – Child Medicaid – Adult Medicaid	NCQA - CAHPS	X	X	X	
Getting Needed Care (2 rates) – Child Medicaid – Adult Medicaid	NCQA - CAHPS	X	X	X	
How Well Doctors Communicate (2 rates) – Child Medicaid – Adult Medicaid	NCQA - CAHPS	X	X	X	
Rating of Health Plan (2 rates) – Child Medicaid – Adult Medicaid	NCQA - CAHPS	X	X	X	
Rating of Personal Doctor (2 rates) – Child Medicaid – Adult Medicaid	NCQA - CAHPS	X	X	X	
Rating of Specialist Seen Most Often (2 rates) – Child Medicaid – Adult Medicaid	NCQA - CAHPS	X	X	X	
Adolescent Well-Care Visits	NCQA/HEDIS	X	X	X	
Adults' Access to Preventive/Ambulatory Health Services (3 rates) – Ages 20 to 44 Years – Ages 45 to 64 Years – Ages 65 and Older	NCQA/HEDIS	X			X
Breast Cancer Screening*	NCQA/HEDIS	X	X	X	X
Cervical Cancer Screening*	NCQA/HEDIS	X	X	X	x

Measure[a]	Measure steward/data source	QRS[b]	FFY 2020 Child or Adult Core Set measure[c]	Pay-for-performance[b,d]	Auto-assignment[b]
Childhood Immunization Status* (2 rates) – Combination 2 – Combination 3	NCQA/HEDIS	X	X	X	x
Children and Adolescents' Access to Primary Care Practitioners (4 rates) – Ages 12 to 24 Months – Ages 25 Months to 6 Years – Ages 7 to 11 Years – Ages 12 to 19 Years	NCQA/HEDIS	X			
Chlamydia Screening in Women*	NCQA/HEDIS	X	X	X	x
Comprehensive Diabetes Care (5 rates) – Hemoglobin A1c (HbA1c) Testing – HbA1c Poor Control (>9.0%) – HbA1c Control (<8.0%) – Eye Exam (Retinal) Performed – Medical Attention for Nephropathy	NCQA/HEDIS	X	X		x
Controlling High Blood Pressure	NCQA/HEDIS	X	X		
Immunizations for Adolescents* (Combination 2)	NCQA/HEDIS	X	X	X	
Lead Screening in Children*	NCQA/HEDIS	X		X	
Medical Assistance With Smoking and Tobacco Use Cessation (3 rates) – Advising Smokers and Tobacco Users to Quit – Discussing Cessation Medications – Discussing Cessation Strategies	NCQA/HEDIS	X	X	x	
Medication Management for People With Asthma* (75% Medication Compliance)	NCQA/HEDIS	X			
Prenatal and Postpartum Care—Postpartum Care	NCQA/HEDIS	X	X	X	X
Prenatal and Postpartum Care—Timeliness of Prenatal Care	NCQA/HEDIS	X	X	X	

Measure[a]	Measure steward/data source	QRS[b]	FFY 2020 Child or Adult Core Set measure[c]	Pay-for-performance[b,d]	Auto-assignment[b]
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (3 rates) – BMI Percentile Documentation—Total – Counseling for Nutrition—Total – Counseling for Physical Activity —Total	NCQA/HEDIS	X	X		
Well-Child Visits in the First 15 Months of Life (6 or More Well-Child Visits)	NCQA/HEDIS	X	X	X	x
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*	NCQA/HEDIS	X	X	X	x

Note: *Plans are required to report these measures stratified by race/ethnicity.

[a] The final measure list for the QRS analysis is subject to change as measures may be removed based on insufficient reporting.

[b] Michigan Department of Health and Human Services (MDHHS). 2015. Michigan Medicaid quality assessment and improvement strategy 2015. Lansing, MI: MDHHS. https://www.michigan.gov/documents/mdhhs/Quality_Strategy_2015_FINAL_for_CMS_112515_657260_7.pdf.

[c] Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020. Adult and Child Health Care Quality Measures. https://www.medicaid.gov/medicaid/quality-of-care/quality-of-care-performance-measurement/adult-and-child-health-care-quality-measures/index.html.

[d] Michigan Department of Health and Human Services (MDHHS). 2020. Comprehensive health care program for the Michigan Department of Health and Human Services. https://www.michigan.gov/documents/contract_7696_7.pdf.

ADHD = attention deficit/hyperactivity disorder; AHRQ = Agency for Healthcare Research and Quality; BMI = body mass index; CAHPS = Consumer Assessment of Healthcare Providers and Systems; CMS = Centers for Medicare & Medicaid Services; HbA1c = hemoglobin A1c; HEDIS = Healthcare Effectiveness Data and Information Set; MCO = managed care organization; NCQA = National Committee for Quality Assurance; PQI = Prevention Quality Indicators; QRS = Quality Rating System.

Appendix C:
Ohio QRS Profile

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OHIO

Ohio Medicaid uses a five-star Quality Rating System (QRS) for their Medicaid managed care organizations (MCOs). Ohio Medicaid offers managed care plans to enrollees in their Covered Families and Children program through comprehensive MCOs. Ohio Medicaid rates their comprehensive MCOs in their QRS report cards. Ohio Medicaid operates several programs—including Aged, Blind, and Disabled (comprehensive MCO + Managed Long-Term Services and Supports plans), Group 8 (Medicaid expansion population), and MyCare Ohio (individuals dually eligible for Medicare and Medicaid in Program of All-Inclusive Care for the Elderly). However, in this profile, we focus exclusively on Ohio's QRS for comprehensive MCOs.

Overview of the managed care environment	
Market overview	• **Total enrollment in Medicaid managed care:** As of July 2017, approximately 2.5 million Medicaid beneficiaries were enrolled in Ohio's managed care programs; this represents 82.7 percent of Medicaid enrollment.[a] • **Managed care organizations:** Ohio has six MCOs operating in the state.[c] – **Market share:** The largest MCO by market share is CareSource (51%). Buckeye Community Health Plan, Molina Healthcare, Paramount Advantage and UnitedHealthcare Community Plan each make-up between 10–13 percent of the market. Aetna Better Health is the smallest MCO by market share (1%).[c] – **Plan performance:** Ohio does not report enrollment based on a MCO's star rating. • **Geographic service area**: Comprehensive MCOs are offered statewide; comprehensive MCO + MLTSS plans are offered by regions and the PACE plan is offered in one county.[b] • **Types of plans offered:** Comprehensive MCO (five plans), Comprehensive MCO + MLTSS (five plans), and PACE (one plan).[b]
Populations covered in the QRS	• Ohio's QRS only rates comprehensive MCOs and does not include any specialty plans in the ratings.
State-level MCO or plan-level quality initiatives	• **Overall strategy:** Ohio Medicaid's quality strategy focuses on three strategic goals for its managed care program: (1) continuously improving population health and health care quality, (2) promoting value over volume, and (3) achieving health equity. There is no explicit mention of the QRS in the strategic goals.[d] • **Overview of plan-level quality initiatives:** Ohio Medicaid has implemented a quality withhold program, a P4P initiative, and an auto-assignment system. All of these programs are tied to quality and are based on different subsets of HEDIS measures that are also included in the QRS. See the section on incentivizing plan performance for more information.[d] The state's quality strategy outlines several additional quality initiatives: – To align with Ohio Medicaid's focus on population health, each health plan is required to develop a model of care that describes "how specialized services and resources are tailored to the health plan's population." This model of care must be reviewed and approved by Ohio Medicaid.[d] – To standardize Ohio Medicaid's quality improvement approach, the Medicaid managed care contracts were updated in 2018 to standardize the program structure and build capacity of health plan leadership teams.[d] – Ohio Medicaid began the Progesterone Initiation PIP to maintain Medicaid eligibility through pregnancy, providing a communication tool for notification of pregnancy; it uses the tool to communicate progesterone needs to managed care plans and other stakeholders and assigns dedicated MCO plan staff as progesterone navigators.[d]

Overview of the managed care environment	
	– Ohio Medicaid, through the MCOs, has funded several community-led efforts to promote better birth outcomes. Ohio Medicaid coordinated town hall meetings, put out requests for proposals, and invested nearly $50 million through 2019 to support these initiatives.[d] – In July 2017, Ohio Medicaid required all MCOs to devote at least one full-time position to community engagement activities to increase community trust, with an effort to improve the plan's ability to address social determinants of health.[d]
Quality Rating System design	
Link to QRS	The 2019 Ohio managed care report card can be accessed here: https://medicaid.ohio.gov/Portals/0/Resources/Reports/mcp-reportcard.pdf
History and evolution of QRS	• **History of the QRS:** The report card was first published in 2015 and will be published for the sixth time in 2020. Over time, plans have provided input on the format, such as the change from three to five stars. Input from extensive stakeholders (including representatives from beneficiaries, provider association groups, and advocacy groups) was solicited in the development of the report card, as well as the plans themselves. • **Evolution of the QRS**: The state Medicaid office reviews and updates the measures within the existing domains.
Rating scales and benchmarks	• **Rating levels:** Ratings for the report card are calculated at the domain level; the report card does not include an overall plan rating.[e] Ohio Medicaid publishes plan performance and 5-year trends on 60 HEDIS measures separately from the QRS. • **Rating scale:** Star ratings for health plans are calculated using a five-category scale. See "Scoring methodology and rules" for more information.[e, f] – 5 stars: Highest performance (The health plan's performance is 2 or more standard deviations above the Ohio Medicaid managed care plan average.) – 4 stars: High performance (The health plan's performance is between 1 and 2 standard deviations above the Ohio Medicaid managed care plan average.) – 3 stars: Average performance (The health plan's performance is within 1 standard deviation of the Ohio Medicaid managed care plan average.) – 2 stars: Low performance (The health plan's performance is between 1 and 2 standard deviations below the Ohio Medicaid managed care plan average.) – 1 star: Lowest performance (The health plan's performance is 2 or more standard deviations below the Ohio Medicaid managed care plan average.) • **Rating benchmark:** Star ratings are benchmarked against all Medicaid managed care plans in Ohio. The rating benchmark is a plan-level average for the measures within each domain.[f]
Quality measures used in the QRS	• **Domains:** Ohio Medicaid managed care plans are rated in the following domains:[f] – Getting Care (4 CAHPS measures and 7 HEDIS measures) – Doctors' Communication and Service (9 CAHPS measures) – Keeping Kids Healthy (16 HEDIS measures) – Living with Illness (16 HEDIS measures)

Quality Rating System design	
	– Women's Health (5 HEDIS measures) • **Measures:** A total of 57 measures are required reporting for the QRS report card (13 CAHPS and 44 HEDIS). Of the 57 measures, 38 of the measures are also Core Set measures. Table C.1 lists the measures and their associated weights.[f] – The Getting Care reporting domain includes adult and child CAHPS composites on ease and speed of receiving needed care. It also includes HEDIS measures to assess access to care, follow-up for mental illness, and adult body mass index assessments. – The Doctors' Communication and Service reporting domain includes adult and child composites for doctors' communication, shared decision making, ratings of doctors and specialists, and medical assistance related to smoking and tobacco cessation. – The Keeping Kids Healthy reporting domain includes HEDIS measures that assess frequency of preventive services, follow-up for ADHD, and care for children and adolescents who use antipsychotics. – The Living with Illness reporting domain includes HEDIS measures that assess care for beneficiaries with chronic conditions, as well as assess medication and pharmacotherapy management and measure the initiation and engagement of treatment for addiction. – The Women's Health reporting domain includes HEDIS measures that assess frequency of women-specific service provision (that is, prenatal and postpartum care as well as breast cancer, cervical cancer, and chlamydia screenings).
Scoring methodology and rules	• **Responsibility for calculating ratings:** Ohio Medicaid's EQRO conducts encounter data accuracy studies, administers provider and consumer satisfaction surveys, validates performance measures, provides administrative reviews for compliance, offers technical assistance, and validates performance improvement projects. The EQRO is also responsible for calculating plan ratings for the report cards.[d] • **Methodology:** Ohio Medicaid's EQRO computes five summary scores for each reporting domain and the summary mean values for the health plans, as a whole. The summary scores are calculated from the health plan's scores on selected HEDIS and CAHPS measures.[f] – To calculate the star ratings, the health plan's summary scores are compared to the unweighted group mean. Using confidence intervals, the EQRO identified plans that were significantly higher or lower than the mean; this tracks to the star ratings assignments. For example, plans whose scores were 2 standard deviations above the mean at the 95 percent confidence interval were assigned 5 stars. Plans that did not fall above or below 0 at the 68 percent confidence intervals received the middle designation (3 stars). – To standardize the measures, the EQRO subtracts the group mean from the measure's score and divides by the group standard deviation. This approach gives each measure equal weight toward the domain rating. However, once each standardized measure score is calculated, the scores are multiplied by the respective measure weights; this produces the plan summary measure score. See Table C.1 for each measure's respective weight in the scoring calculations. – Ratings are not risk adjusted to reflect differences in populations across Ohio.

Quality Rating System design	
Rating display and formats	• **Rating display:** Report cards are available on the Ohio Medicaid website. The report cards include a brief description of the QRS, a key to understand the rating scale, a brief description of each performance domain, and a table which showcases each plan's ratings. On the second page of the report card, there are several questions beneficiaries are encouraged to ask themselves when selecting a plan and a list of additional resources.[e] • **Format of QRS:** Ratings are presented in a PDF-based report card and included in beneficiary enrollment materials.[e] • **Plan changes over time:** There is no indication of change in plan performance over time in the report card.[e] • **Data issues:** Ohio Medicaid acknowledges three different types of missing values in HEDIS and CAHPS data: not reported data, materially biased data (from HEDIS Compliance Audit), and insufficient amount of data. If the missing values for the measures are from unreported or materially biased data, the plan is assigned the minimum performance rate for the measure observed across all plans. If the missing values are from insufficient amounts of data, the plan is assigned the average value of the measure.[f] • **Frequency of rating updates:** The report card is published annually in December using HEDIS and CAHPS information from that same year. Note that HEDIS measurement years generally cover services delivered in the prior calendar year.
Stakeholder engagement in QRS development and updates	• Ohio Medicaid, in collaboration with their EQRO, selected measures for the 2019 health plan report cards. Selection of measures was based on consumer usability, validity, and availability of data and nationally recognized/standardized measures. • While the state does not track how consumers use the QRS, beneficiary input was sought in developing the language and presentation of the information on the report card. MCOs have been given the opportunity to provide feedback on proposed changes to the methodology.
Quality Ratings Systems uses	
Informing beneficiary choice	• Ohio Medicaid publishes four quarterly consumer dashboards summarizing managed care plans' performance in key operational areas: utilization of inpatient psychiatric, Medicaid providers, Medicaid consumers, and Medicaid panel maps. The measures on the dashboards do not align with the QRS.[j] – The inpatient psychiatric dashboard reports on utilization data, including average lengths of stay and number of total inpatient psychiatric admissions. – The Medicaid provider dashboard tracks provider complaints, prior authorizations, and prompt pay. – The Medicaid consumer dashboard reports member complaints, appeals, and state hearings. – The Medicaid panel maps dashboard displays county-level information on the Medicaid managed care provider network.
Incentivizing plan performance	• **Auto-assignment**: Ohio Medicaid implemented Quality-Based Assignments as part of the assignment process for consumers who "did not have a prior history with specific providers or have not chosen" a managed care plan. The Quality-Based Assignments formula aggregates results for measures related to women's health and infant mortality to calculate a "Women's Health Index." There are five measures that make up this index. Four of those measures are included in Ohio's QRS (Breast Cancer Screening, Cervical Cancer Screening, Prenatal and Postpartum Care:

Quality Ratings Systems uses	
	Timeliness of Prenatal Care, and Prenatal and Postpartum Care: Postpartum Care), and one of those measures is not in the QRS (Percent of Live Births Weighing Less Than 2,500 Grams). Ohio Medicaid compares plan performance using this index to assign members to a managed care plan on a quarterly basis. Plans with higher performance receive a greater percentage of new Medicaid enrollees assigned to them.[h] • **Capitation withhold:** Ohio Medicaid introduced a quality-based capitation withhold system in 2018, which withholds 2 percent of the calendar year capitation and delivery payments for each managed care plan for use in the withhold program. Ohio Medicaid measures the plans' performance on four different indices: Behavioral Health, Cardiovascular Disease, Healthy Children, and Diabetes. Each index is comprised of multiple HEDIS measures; all 15 of the HEDIS measures for the withhold program are also included in Ohio's QRS. Please see Table C.1 for a detailed list of the withhold measures. Payouts from the withhold program are index-specific, and potential payout per index will equal the total withhold amount divided by four.[d, g] • **Pay-for-performance**: Ohio Medicaid has historically operated a P4P incentive system. The P4P incentive system is applied to the CFC and ABD programs. For the 2018 state fiscal year, each plan received two P4P incentive determinations: one for clinical quality and the other for care management readiness and performance. Results for each P4P measure are calculated per plan statewide and include all regions in which the health plan has membership. The P4P program includes six HEDIS measures, all of which are also included in the QRS. Please see Table C.1 for a detailed list of the P4P measures. [d, h] The P4P incentive system was phased out beginning in 2018 when Ohio introduced its quality-based capitation withhold system.
Conducting plan oversight	• **Demographic information:** Ohio Medicaid requires health plans to use demographic information to "promote culturally competent service delivery and to progress toward the goal of reducing health disparities." Demographic data (including age, race, ethnicity, sex, primary language, and disability status) are collected at the point of beneficiary enrollment, but beneficiaries are not required to respond; thus, this information is missing for 25 percent of beneficiaries.[d] – Health plans are also required to maintain ongoing quality assurance and performance improvement programs. Health plans must submit yearly updates to Ohio Medicaid. As part of their submissions, health plans describe how they will deliver service in culturally effective manners and specify measures that will be used for tracking improvements.[d] • **Oversight mechanisms:** Ohio Medicaid may impose sanctions or remedial actions for plans that violate their contracts or do not meet performance standards. Ohio Medicaid uses established Quality Measures and Standards to determine performance incentives and/or determine plan noncompliance sanctions. Thirty-seven of the measures listed as Quality Measures and Standards are also part of Ohio's QRS report card. These actions may include corrective action plans, point accumulation for violations, financial sanctions due to accumulated points, progressive sanctions, quality improvement directives, new member enrollment freezes, reduction of assignments, and/or termination of provider agreement.[d] About 20 measures are used for both incentive and disincentive programs, which drive quality improvement priorities.

[a] Medicare Payment Advisory Commission (MedPAC). 2019. Program enrollment and spending: Medicaid managed care. https://www.macpac.gov/macstats/medicaid-managed-care/.

[b] Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018. Medicaid managed care enrollment report: 2018 managed care enrollment by program and plan. https://data.medicaid.gov/Enrollment/2018-Managed-Care-Enrollment-by-Program-and-Plan/5gyf-8cgz/data.

[c] Kaiser Family Foundation. 2019. Medicaid MCO enrollment by plan and parent firm. https://www.kff.org/medicaid/state-indicator/medicaid-mco-enrollment-by-plan-and-parent-firm-march-2019/?currentTimeframe=0&sortModel=%7B%22colId%22:%22State%22,%22sort%22:%22asc%22%7D.

[d] Office of Health Innovation and Quality, Ohio Department of Medicaid. 2018. The Ohio Department of Medicaid Managed Care Quality Strategy. Columbus, OH: Ohio Department of Medicaid. https://medicaid.ohio.gov/Portals/0/Medicaid%20101/QualityStrategy/Measures/MCQ-Strategy2018.pdf.

[e] Ohio Department of Medicaid. 2020. 2020 Managed care plans report card. Columbus, OH: Ohio Department of Medicaid. https://medicaid.ohio.gov/Portals/0/Resources/Reports/mcp-reportcard.pdf.

[f] Ohio Department of Medicaid and Health Services Advisory Group, Inc. 2019. Ohio Department of Medicaid 2019: Managed care plan report card methodology. Columbus, OH: Ohio Department of Medicaid. https://medicaid.ohio.gov/Portals/0/Resources/Reports/2019-MCP-Report-Card-Methodology.pdf.

[g] Ohio Department of Medicaid. 2019. 2019 MCP quality withhold: Measurement year 2018. Columbus, OH: Ohio Department of Medicaid. https://medicaid.ohio.gov/Portals/0/Resources/Reports/2019-MMC-Quality-Withhold.pdf.

[h] Ohio Department of Medicaid and Health Services Advisory Group, Inc. 2020. State fiscal year 2019: Annual EQRO technical report. Columbus, OH: Ohio Department of Medicaid.

https://medicaid.ohio.gov/Portals/0/Medicaid%20101/QualityStrategy/Measures/SFY-2019-External-Quality-Review-Technical-Report.pdf.

[i] Ohio Department of Medicaid. 2020. Episodes of care. https://medicaid.ohio.gov/provider/PaymentInnovation/episodes.

[j] Ohio Department of Medicaid. 2020. Managed care dashboards. https://medicaid.ohio.gov/Managed-Care/Dashboards.

ABD = Aged, Blind, and Disabled; ADHD = attention deficit hyperactivity disorder; CAHPS = Consumer Assessment of Healthcare Providers and Systems; CFC = Covered Families and Children; CI = confidence interval; CPC = Comprehensive Primary Care; EQRO = External Quality Rating Organization; HEDIS = Healthcare Effectiveness Data and Information Set; MCO = managed care organization; MLTSS = Managed Long-Term Services and Supports; PACE = Program of All-Inclusive Care for the Elderly; PIP = performance improvement project; P4P = pay-for-performance; QBA = Quality-Based Assignments; QRS = Quality Rating System.

Table C.1. Measures reported by Ohio Medicaid health plans by quality initiative, 2019

Measures	QRS (QRS weight)[a,c,e]	Used in quality withhold program[b]	Listed as quality measures and standards [a,c]	Used in pay-for-performance program[c]	Used in quality-based auto-assignment[c]	FFY 2020 Child or Adult Core Set measure*[d]
Domain: Getting Care						
Child Medicaid—Getting Needed Care (CAHPS Composite)	X (1)					X
Adult Medicaid—Getting Needed Care (CAHPS Composite)	X (1)					X
Child Medicaid—Getting Care Quickly (CAHPS Composite)	X (1)					X
Adult Medicaid—Getting Care Quickly (CAHPS Composite)	X (1)					X
Adult Body Mass Index Assessment	X (1)	X (Diabetes Index)	X			X
Adults' Access to Preventative/Ambulatory Health Services: Total	X (1)		X			
Children and Adolescents' Access to Primary Care Practitioners: Ages 12–24 Months	X (1/4)		X			
Children and Adolescents' Access to Primary Care Practitioners: Ages 25 Months–6 Years	X (1/4)		X			
Children and Adolescents' Access to Primary Care Practitioners: Ages 7–11 Years	X (1/4)		X			
Children and Adolescents' Access to Primary Care Practitioners: Ages 12–19 Years	X (1/4)		X			
Follow-Up After Hospitalization for Mental Illness: 7 Day Follow-Up—Total	X (1)	X (Behavioral Health Index)	X	X		X

Measures	QRS (QRS weight)[a,c,e]	Used in quality withhold program[b]	Listed as quality measures and standards [a,c]	Used in pay-for-performance program[c]	Used in quality-based auto-assignment[c]	FFY 2020 Child or Adult Core Set measure*[d]
Domain: Doctors' Communication and Service						
Child Medicaid—How Well Doctors Communicate (CAHPS Composite)	X (1)					X
Adult Medicaid—How Well Doctors Communicate (CAHPS Composite)	X (1)					X
Child Medicaid—Shared Decision Making (CAHPS Composite)	X (1)					
Adult Medicaid—Shared Decision Making (CAHPS Composite)	X (1)					
Child Medicaid—Rating of Personal Doctor (CAHPS Global Rating)	X (1)					X
Adult Medicaid—Rating of Personal Doctor (CAHPS Global Rating)	X (1)					X
Adult Medicaid—Rating of Specialist Seen Most Often (CAHPS Global Rating)	X (1)					X
Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit	X (1/3)					X
Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications	X (1/3)					X
Domain: Keeping Kids Healthy						
Adolescent Well-Care Visits	X (1)	X (Healthy Children Index)	X	X		X
Annual Dental Visits: Total	X (1)		Reporting only			
Childhood Immunization Status: Combo 2	X (1/3)		Reporting only			X

Measures	QRS (QRS weight)[a,c,e]	Used in quality withhold program[b]	Listed as quality measures and standards [a,c]	Used in pay-for-performance program[c]	Used in quality-based auto-assignment[c]	FFY 2020 Child or Adult Core Set measure*[d]
Childhood Immunization Status: Combo 3	X (1/3)		Reporting only			X
Childhood Immunization Status: Combo 10	X (1/3)		Reporting only			X
Immunizations for Adolescents: Combo 1	X (1/2)		Reporting only			X
Immunizations for Adolescents: Human Papillomavirus Vaccine	X (1/2)		Reporting only			X
Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	X (1/2)		Reporting only			X
Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	X (1/2)		Reporting only			X
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics: Total	X (1)	X (Behavioral Health Index)	X			X
Use of Multiple Concurrent Antipsychotics in Children and Adolescents: Total	X (1)		X			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Percentile Documentation—Total	X (1/3)	X (Healthy Children Index)	X			X
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Counseling for Nutrition—Total	X (1/3)		Reporting only			X
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Counseling for Physical Activity—Total	X (1/3)		Reporting only			X

Measures	QRS (QRS weight)[a,c,e]	Used in quality withhold program[b]	Listed as quality measures and standards [a,c]	Used in pay-for-performance program[c]	Used in quality-based auto-assignment[c]	FFY 2020 Child or Adult Core Set measure*[d]
Well-Child Visits in the First 15 Months of Life: 6 or More Visits	X (1)	X (Healthy Children Index)	X			X
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	X (1)	X (Healthy Children Index)	X			X
Domain: Living With Illness						
Antidepressant Medication Management: Effective Acute Phase Treatment	X (1/2)		X			X
Antidepressant Medication Management: Effective Continuation Phase Treatment	X (1/2)		Reporting only			X
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	X (1/6)		Reporting only			
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	X (1/6)	X (Cardiovascular Disease Index)	X	X		X
Comprehensive Diabetes Care: HbA1c Testing	X (1/6)	X (Cardiovascular Disease Index)	X			
Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)	X (1/6)	X (Cardiovascular Disease Index)	X			
Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	X (1/6)	X (Cardiovascular Disease Index)	X			
Comprehensive Diabetes Care: Medical Attention for Nephropathy	X (1/6)		Reporting only			
Controlling High Blood Pressure	X (1)	X (Diabetes Index)	X	X		X
Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment: Initiation of AOD Treatment—Total	X (1/2)	X (Behavioral Health Index)	X			X

Measures	QRS (QRS weight)[a,c,e]	Used in quality withhold program[b]	Listed as quality measures and standards [a,c]	Used in pay-for-performance program[c]	Used in quality-based auto-assignment[c]	FFY 2020 Child or Adult Core Set measure*[d]
Initiation and Engagement of AOD Abuse or Dependence Treatment: Engagement of AOD Treatment—Total	X (1/2)		Reporting only			X
Medication Management for People With Asthma: Medication Compliance 75 Percent	X (1)		X			
Pharmacotherapy Management of COPD Exacerbation: Systemic Corticosteroid	X (1/2)		Reporting only			
Pharmacotherapy Management of COPD Exacerbation: Bronchodilator	X (1/2)		Reporting only			
Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy—Total	X (1)	X (Diabetes Index)	X			
Statin Therapy for Patients With Diabetes: Received Statin Therapy—Total	X (1)		X			
Domain: Women's Health						
Breast Cancer Screening	X (1)		X		X	X
Cervical Cancer Screening	X (1)		X		X	X
Chlamydia Screening in Women: Total	X (1)		Reporting only			X
Prenatal and Postpartum Care: Timeliness of Prenatal Care	X (1)		X	X	X	X
Prenatal and Postpartum Care: Postpartum Care	X (1)		X	X	X	X

*Note: FFY 2020 Core Set measures generally cover services provided during calendar year 2019.

[a] Office of Health Innovation and Quality, Ohio Department of Medicaid. 2018. The Ohio Department of Medicaid Managed Care Quality Strategy. Columbus, OH: Ohio Department of Medicaid. https://medicaid.ohio.gov/Portals/0/Medicaid%20101/QualityStrategy/Measures/MCQ-Strategy2018.pdf.

[b] Ohio Department of Medicaid. 2019. 2019 MCP quality withhold: Measurement year 2018. Columbus, OH: Ohio Department of Medicaid. https://medicaid.ohio.gov/Portals/0/Resources/Reports/2019-MMC-Quality-Withhold.pdf.

[c] Ohio Department of Medicaid and Health Services Advisory Group, Inc. 2020. State fiscal year 2019: Annual EQRO technical report. Columbus, OH: Ohio Department of Medicaid. https://medicaid.ohio.gov/Portals/0/Medicaid%20101/QualityStrategy/Measures/SFY-2019-External-Quality-Review-Technical-Report.pdf.

[d] Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020. Adult and Child Health Care Quality Measures. https://www.medicaid.gov/medicaid/quality-of-care/quality-of-care-performance-measurement/adult-and-child-health-care-quality-measures/index.html.

[e] Ohio Department of Medicaid and Health Services Advisory Group, Inc. 2019. Ohio Department of Medicaid 2019: Managed care plan report card methodology. Columbus, OH: Ohio Department of Medicaid. https://medicaid.ohio.gov/Portals/0/Resources/Reports/2020-MCP-Report-Card-Methodology.pdf.

ADHD = attention deficit hyperactivity disorder; AOD = alcohol and other drug; BMI = body mass index; CAHPS = Consumer Assessment of Healthcare Providers and Systems; COPD = chronic obstructive pulmonary disease; FFY = federal fiscal year; HbA1c = hemoglobin A1c; QRS = Quality Rating System.

Appendix D:
Pennsylvania QRS Profile

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PENNSYLVANIA

Pennsylvania Medicaid uses a four-star Quality Rating System (QRS) for their eight Medicaid managed care organizations (MCOs), published as a 'Consumer Guide' for each of the state's geographic zones. HealthChoices, Pennsylvania's Medicaid program, is comprised of separate programs for comprehensive physical health, behavioral health, and long-term services and supports. In this profile, we focus on plans that are in the Physical Health HealthChoices program (the only program for which the QRS calculates a star rating).

Overview of the managed care environment	
Market overview	• **Total enrollment in Medicaid managed care**: As of 2019, Pennsylvania has approximately 2.9 million beneficiaries covered by Medicaid and CHIP; of these beneficiaries, 2.6 million are covered by Medicaid managed care, representing 90 percent of all Medicaid enrollment.[a,b] • **Managed care organizations**: There are nine MCOs offering plans in the state's physical HealthChoices program as of March 2020.[c] – **Market share**: The largest MCOs by market share are University of Pittsburgh Medical Center plans and Keystone (each with 19% market share), followed by AmeriHealth (Caritas and Northeast) with 13 percent market share, Gateway with 12 percent market share, Health Partners with 10 percent market share, UnitedHealthcare with 10 percent market share, CVS/Aetna with 9 percent market share, and Geisinger with 8 percent market share.[c] – **Plan performance:** Pennsylvania does not report enrollment based on a MCO's star rating. • **Geographic service area**: Physical health plans are contracted to provide services regionally. The state is divided into five regional service zones: Southeast, Southwest, North West, Lehigh/Capital, and North East.[d] • **Types of plans offered:** – Physical health plans: nine plans[c] – CHIP: eight plans[e] – Behavioral health services (carved out from physical health): five plans[d] – Community HealthChoices (Comprehensive MCO + MLTSS): four plans[f] – Adult Community Autism Program (Other PHP): state-administered program with limited benefits[f] – Medical Assistance Transportation Program (Non-Emergency Transportation): state-administered program with limited benefits[g]
Populations covered in the QRS	• Pennsylvania's report cards only rate physical health plans, and they do not include any specialty plans in the ratings.
State-level MCO or plan-level quality initiatives	• **Overall strategy:** Pennsylvania's mandatory managed care program, called HealthChoices, has three goals: improve access to health care services, improve quality of care for beneficiaries, and stabilize Pennsylvania's spending. HealthChoices has committed to increasing use of value-based purchasing agreements to improve quality of care in MCOs—such as P4P, patient-centered medical homes, shared savings contractual arrangements, bundled or global payment arrangements, and full risk or ACO payment agreements. Priorities initially targeted by the value-based purchasing agreements were improved access to pediatric dental services and reduction in

Overview of the managed care environment	
	unnecessary hospitalizations.[h] More recent focus areas include strengthening care coordination and encouraging transitions from nursing facilities to community-based care.[j] • **Pay-for-performance**: The HealthChoices MCOs participate in a P4P program, where the MCO can earn up to an additional 2 percent of total premium payments with higher performance.[m] For 2020, Pennsylvania Medicaid selected ten HEDIS measures and two state-specified measures as quality indicators for calendar year 2019 for the MCO P4P program (see Table D.1 for measures).
Quality Rating System design	
Link to QRS	The Pennsylvania 2019 Consumer Guides for Physical HealthChoices can be accessed here: http://www.healthchoices.pa.gov/providers/resources/publications/physical/index.htm
History and evolution of the QRS	• **History of the QRS**: The QRS dates back to at least 2012.[6] • **Evolution of the QRS:** The quality measures represented in the QRS were chosen to align with important initiatives within the Commonwealth. The QRS quality measures are reviewed annually and revised as necessary.
Rating scales and benchmarks	• **Rating levels**: Star ratings are calculated at the domain level for nine domains; an overall quality rating is not included in the QRS. • **Rating scale**: A four-category rating system is used, where one star indicates lowest performance, and four stars indicates highest performance. • **Rating benchmarks**: Ratings are calculated by comparing plan performance at the regional level. Plans submit data for quality measures based on their statewide performance, but ratings are calculated separately for plans operating in each of the state's geographic zones—which effectively rates each MCO in comparison to their peers in each zone.
Quality measures used in the QRS	• **Domains**: QRS measures are dividing into the following domains: – Asthma (1 HEDIS measure) – Children's Dental (1 HEDIS measure and 1 Pennsylvania performance measure) – Children's Health (8 HEDIS measures) – High Blood Pressure (2 HEDIS measures) – Diabetes (4 HEDIS measures) – Maternity (2 HEDIS measures and 1 Pennsylvania performance measure) – Women's Health (2 HEDIS measures) – Getting Needed Care (4 CAHPS adult measures and 4 CAHPS child measures) – Satisfaction with Health Plans (1 CAHPS adult measure and 1 CAHPS child measure) • **Measures:** A total of 32 quality measures across 9 domains are used to calculate the star ratings in the Pennsylvania Physical Health Consumer Guides.[i] These 32 measures are a subset of the more comprehensive list of 243 HEDIS, 25 PA-PMs, and 71 adult and child CAHPS measures that PH-MCOs submit to the state.[i,p] Of the 32

[6] Year established is based on Mathematica's review of available documentation and the recollection of state Medicaid officials interviewed.

Quality Rating System design	
	measures used in the QRS, 17 are also Core Set measures. Table D.1 lists the subset of measures and the relevant reporting programs.
Scoring methodology and rules	• **Responsibility for calculating ratings:** Pennsylvania's EQRO validates the quality measure data. State staff use the validated rates to calculate the QRS ratings. • **Methodology:** Star ratings for our Consumer Guide Performance Area are calculated using the three-step process laid out below. Ratings are not risk adjusted. **1.** Calculate z-scores for measures **2.** Calculate composite scores for Consumer Guide Performance Areas **3.** Calculate the star rating value from the composite score
Rating display and formats	• **Rating display:** Pennsylvania publishes the Consumer Guides annually for the Physical HealthChoices program; the guides include star ratings for plans offered in the zone. These Consumer Guides are available on the Pennsylvania HealthChoices website. Consumer Guides with star ratings are not published for plans offering CHIP, Behavioral HealthChoices (behavioral health plans), or Community HealthChoices (MLTSS).[l] • **Format of QRS:** Ratings are presented in a PDF-based Consumer Guide and included in beneficiary enrollment materials. • **Plan changes over time**: There is no indication of change in plan performance over time in the QRS. • **New plans**: A new MCO would not be included in the QRS document for their first-year performance. • **Data issues**: If a MCO did not report a rate for a quality measure, that measure would not be included in the composite for that measure. • **Frequency of rating updates**: The Consumer Guides are updated and published annually, and they reflect data from the prior year that is made available as of late February.
Stakeholder engagement in QRS development and updates	In the initial development of the QRS document, the information was shared with beneficiaries serving on the state's Consumer Subcommittee.
Quality Ratings Systems uses	
Informing beneficiary choice	• **Measure-level reports**: Consumers have access to measure-level scores in a separate resource; the link to these scores is included in the Consumer Guides. • **Trends over time**: Each year, Pennsylvania publishes a HealthChoices Trending Report that presents trends in the quality domains featured in the Consumer Guides over the past three years. This report is separate from the Consumer Guides but is published on the same webpage.[k]
Incentivizing plan performance	• **Auto-assignment**: Consumers who do not select a MCO are auto-assigned to one in their geographic zone. The state's auto-assignment algorithm is not tied to quality performance; it equally assigns beneficiaries based on the number of plans operating in the beneficiary's zone.[k] • **Pay-for-performance**: The program allocates2percent of capitation to MCOs that meet performance benchmarks on measures included in its P4P program.[m] One percent of the incentive pool is for the MCOs' performance in comparison to national benchmarks, and the remaining one percent is for the MCO's year-over-year improvement

Quality Ratings Systems uses	
	on each measure (for example, the MCOs' comparison to their individual previous year performance).[o] MCOs are also subject to payment penalties if they do not meet the 50th percentile national benchmark for HEDIS measures. However, for Pennsylvania Performance Measures (PAPMs), MCOs are required to meet a state-specified goal. There are no payment penalties for not meeting the state-specified PAPM goals.[o]
Conducting plan oversight	• Pennsylvania's EQRO conducts an annual review of MCO performance on quality measures that go beyond those used in the star rating calculations for the state's QRS. The EQRO review focuses only on HEDIS measures in this review and does not include any of the state-specified measures the state uses or any non-HEDIS measures that plans report for the Child and Adult Core Sets.[k] • The EQRO also assesses MCO compliance with federal and state requirements around enrollee rights and protections, quality assessment and performance improvement, grievance system standards, and certification and program integrity. • In 2019, performance improvement projects for physical health MCOS focused on (1) improving access to pediatric preventive dental care and (2) reducing potentially preventable hospital admissions and readmissions and emergency department visits.[k] • **Oversight mechanisms:** Pennsylvania Medicaid does not use the QRS ratings specifically for any plan oversight purposes. For any quality measure included in the composite for that measure, the Department conducts Quarterly Quality Review Meetings with each MCO to discuss those HEDIS measures below the 50th percentile and initiatives they have in place or will be implementing to improve their rate. • **Demographic information:** Pennsylvania does not use race or ethnicity data in the calculation of the QRS star rating. Pennsylvania does collect race and ethnicity data on a subset of HEDIS measures. In calendar year 2021, Pennsylvania will be implementing a Health Equity Pay-for-Performance Program.

[a] Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020. Medicaid managed care enrollment report: 2018 management care enrollment summary. https://data.medicaid.gov/Enrollment/2018-Managed-Care-Enrollment-Summary/gn4b-7d7q/data.

[b] Medicaid and CHIP Payment and Access Commission (MACPAC). 2019. *MACStats: Medicaid and CHIP data book*. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2020/01/MACStats-Medicaid-and-CHIP-Data-Book-December-2019.pdf.

[c] Pennsylvania Department of Human Services. 2020. Monthly physical health managed care program enrollment report. March 2020. https://www.dhs.pa.gov/providers/Providers/Documents/Managed%20Care%20Enrollment%20Information/2020%20Mar%20Enrollment%20Report.pdf.

[d] Pennsylvania Department of Human Services. 2020. Pennsylvania Medicaid managed care organization (MCO) directory. https://www.dhs.pa.gov/providers/Providers/Documents/Managed%20Care%20Information/MA%20MCO%20Directory.pdf.

[e] Children's Health Insurance Program (CHIP), Pennsylvania Department of Human Services. 2020. Enrollment by county. https://www.chipcoverspakids.com/AboutCHIP/Pages/EnrollmentFigures.aspx.

[f] Pennsylvania Department of Human Services. Community HealthChoices. http://www.healthchoices.pa.gov/info/about/community/index.htm.

[g] Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018. Medicaid managed care enrollment report: 2018 Managed care enrollment by program and plan. https://data.medicaid.gov/Enrollment/2018-Managed-Care-Enrollment-by-Program-and-Plan/5gyf-8cgz/data

[h] Pennsylvania Department of Human Services. 2017. Medical assistance quality strategy for PA. Harrisburg, PA: Pennsylvania Department of Human Services. http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_260569.pdf.

[i] Pennsylvania Department of Human Services and Island Peer Review Organization (IPRO). 2020. 2019 external quality review report: Statewide Medicaid managed care annual report. Harrisburg, PA: Pennsylvania Department of Human Services. http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/report/c_277776.pdf.

[j] Kaiser Family Foundation. 2018. States focus on quality and outcomes amid waiver changes: Results from a 50-state Medicaid budget survey for state fiscal years 2018 and 2019. https://www.kff.org/report-section/states-focus-on-quality-and-outcomes-amid-waiver-changes-managed-care-initiatives/.

[k] Pennsylvania Department of Human Services. 2020. Health Choices Physical Health Agreement. Harrisburg, PA: Pennsylvania Department of Human Services. http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/p_040149.pdf.

[l] Pennsylvania Department of Human Services. A guide to Pennsylvania's Medicaid HealthChoices health plans: 2019 Southeast zone. Harrisburg, PA: Pennsylvania Department of Human Services. http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_261082.pdf.

[m] Primary Care Collaborative. 2014. HealthChoice managed care organization. https://www.pcpcc.org/initiative/healthchoice-managed-care-organization.

[o] State Health Access Data Assistance Center. 2014. Paying for value in Medicaid: A synthesis of advanced payment models in four states. http://essentialhospitals.org/wp-content/uploads/2014/08/MACPAC_Visits_Final-Report-Feb-2014.pdf.

[p] Pennsylvania Department of Human Services. 2019. HealthChoices: Consumer guide rate chart by performance area. http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_260095.pdf.

ACO = accountable care organization; CAHPS = Consumer Assessment of Healthcare Providers and Systems; CHIP = Children's Health Insurance Program; EQRO = External Quality Rating Organization; HEDIS = Healthcare Effectiveness Data and Information Set; MCO = managed care organization; MLTSS = Managed and Long-Term Services and Supports; PA-PM =Pennsylvania Performance Measure; PH-MCO = physical health managed care organization; PHP = prepaid health plan; P4P = pay-for-performance; QRS = Quality Rating System.

https://data.medicaid.gov/Enrollment/2018-Managed-Care-Enrollment-by-Program-and-Plan/5gyf-8cgz/data

Table D.1. Measures reported by Pennsylvania Medicaid health plans by quality initiative as of August 2020

Measures required for Pennsylvania QRS by domain	QRS[a]	FFY 2020 Child or Adult Core Set measure[b]	Pay-for-performance measure[a]	Measure data source
Asthma				
Medication Management for People with Asthma (75% compliance), Ages 5 to 64	X		X	HEDIS
Children's Dental				
Annual Dental Visit, Ages 2 to 20	X		X	HEDIS
Annual Dental Visits for Members with Developmental Disabilities, Ages 2 to 21	X			PA Performance Measure
Children's Health				
Well-Child Visits in the First 15 Months of Life (6 or More Visits)	X	X	X	HEDIS
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	X	X	X	HEDIS
Children's Access to PCPs, Ages 12 to 24 Months	X	X		HEDIS
Children's Access to PCPs, Ages 25 Months to 6 Years	X	X		HEDIS
Children's Access to PCPs, Ages 7 to 11 Years	X	X		HEDIS
Children's Access to PCPs, Ages 12 to 19 Years	X	X		HEDIS
Adolescent Well-Care Visits	X	X	X	HEDIS
Lead Screening in Children	X			HEDIS
High Blood Pressure				
Controlling High Blood Pressure, Ages 18 to 85	X	X	X	HEDIS
Comprehensive Diabetes Care: BP Control (<140/90 mm hg)	X	X		HEDIS
Diabetes				
Hemoglobin A1c Screening for People with Diabetes	X			HEDIS
Hemoglobin A1c Poorly Controlled in People with Diabetes	X		X	HEDIS
Eye Exam for People with Diabetes	X			HEDIS
Medical Attention for Nephropathy	X			HEDIS
Maternity				
Frequency of Ongoing Prenatal Care, 81+ Percent of Recommended Visits	X		X	PA Performance Measure
Prenatal Care in First Trimester	X	X	X	HEDIS

Measures required for Pennsylvania QRS by domain	QRS[a]	FFY 2020 Child or Adult Core Set measure[b]	Pay-for-performance measure[a]	Measure data source
Postpartum Care	X	X	X	HEDIS
Women's Health				
Breast Cancer Screening, Ages 52 to 74	X	X		HEDIS
Cervical Cancer Screening, Ages 21 to 64	X	X		HEDIS
Getting Needed Care—Adult				
Getting Needed Care Right Away (usually or always)	X	X		CAHPS
Getting Appointment with Specialist (usually or always)	X			CAHPS
Getting Care You Need (usually or always)	X	X		CAHPS
Appointment for Routine Care When Needed (usually or always)	X			CAHPS
Getting Needed Care—Child				
Getting Needed Care Right Away for Your Child (usually or always)	X	X		CAHPS
Appointment for Routine Care When Needed (usually or always)	X			CAHPS
Getting Appointment with Specialist for Your Child (usually or always)	X			CAHPS
Getting Care Your Child Needs (usually or always)	X	X		CAHPS
Satisfaction with Health Plan				
Satisfaction with Health Plan (Rating 8–10) – Adult	X			CAHPS
Satisfaction with Child's Health Plan (Rating 8–10) – Child	X			CAHPS

[a] Pennsylvania Department of Human Services. 2019. HealthChoices: Consumer guide rate chart by performance area. http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_260095.pdf.

[b]Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services.2020. Adult and Child Health Care Quality Measures. https://www.medicaid.gov/medicaid/quality-of-care/quality-of-care-performance-measurement/adult-and-child-health-care-quality-measures/index.html.

BP = blood pressure; CAHPS = Consumer Assessment of Healthcare Providers and Systems; HEDIS = Healthcare Effectiveness Data and Information Set; PCP = primary care provider; QRS = Quality Rating System.

Appendix E:
Texas QRS Profile

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TEXAS

Texas Medicaid uses a five-star Quality Rating System (QRS) for their Medicaid managed care organizations (MCOs). Ratings are published as a report card for each of the state's 13 services areas for 3 of the state's 4 Medicaid programs[7] (STAR, STAR Kids, and STAR + PLUS) and for the Children's Health Insurance Program. Texas Medicaid report cards allow beneficiaries to see how each MCO's performance compares to other MCOs in their service area. In this profile, we focus exclusively on Texas' QRS for STAR, which serves pregnant women and children.

Overview of the managed care environment	
Market overview	• **Total enrollment in Medicaid managed care:** As of December 2019, approximately 4.1 million Medicaid beneficiaries were enrolled in Texas' managed care programs; this represents 94.7 percent of Medicaid enrollment.[a,b] • **Managed care organizations:** As of December 2019, Texas had 18 MCOs operating in the state. These MCOs may participate in multiple programs. – **Market share:** As of December 2019, the largest MCOs by market share include Centene (Superior) (25%), Anthem (Amerigroup) (19%), Texas Children's Health Plan (10%), and UnitedHealth Group (8%). All others make up the remaining share of the market.[d] – **Plan performance:** In 2018, Texas Medicaid published 62 unique report cards across 4 managed care programs (STAR: Adult and Child, STAR Kids, STAR+PLUS, and CHIP). Ratings were assigned at the plan code[8] level. Across all programs, 15 plan codes were rated at 5 stars, 47 were rated as 4 stars, 51 were rated as 3 stars, 41 were rated as 2 stars, and 19 were rated as 1-star.[g] Based on 2020 report card scores, approximately 16 percent of Medicaid managed care members were enrolled in a 5-star plan; 30 percent of Medicaid managed care members were enrolled in a 4-star plan; 44 percent of Medicaid managed care members were enrolled in a 3-star plan; 9 percent of Medicaid managed care members were enrolled in a 2-star plan; and 1 percent of Medicaid managed care members were enrolled in a 1-star plan. • **Geographic service area:** Medical plans are contracted to provide services regionally by service area.[c] Texas Medicaid splits the state in 13 service areas and publishes a QRS report card for each service area by program. • **Types of plans offered:** Comprehensive MCO + MLTSS (Programs: STAR Kids, STAR+PLUS, STAR Health); MCOs participating in programs: 12), Comprehensive MCO (Program: STAR; MCOs participating in program: 15), CHIP (MCOs participating in program: 15); Dental PAHP (Programs: Children's Medicaid Dental Services, CHIP Dental; Plans participating in programs: 3).[d]

[7]The four different programs are STAR, STAR + PLUS, STAR Kids, and STAR Health. STAR covers low-income children, pregnant women, and families. STAR+PLUS covers people who have disabilities or are age 65 or older. STAR Kids cover children and adults age 20 and younger who have disabilities. STAR Health covers children in Department of Family and Protect Services conservatorship, children in the Adoption Assistance or Permanency Care Assistance program who are transitioning from STAR Health to STAR or STAR Kids, youth age 21 years and younger with voluntary extended foster care placement agreements, and youth age 20 and younger who are Former Foster Care Children.

[8] The term "plan code" denotes MCO, program (STAR, CHIP, etc.), and service area.

Overview of the managed care environment	
Populations covered in the QRS	• STAR (low-income children, pregnant women, and families) receives distinct report card ratings for the STAR Adult and STAR Child population served by this program. CHIP, STAR Kids (children and adults age 20 and younger who have disabilities), and STAR + PLUS (adults who have disabilities or are age 65 or older) programs are also rated in the QRS. Each MCO is rated by program and within its service area.[e]
State-level MCO or plan-level quality initiatives	• **Overall strategy:** Texas's priority goals identified in the quality strategy include transitioning from volume-based purchasing models to a pay-for-performance model, improving member satisfaction with care, and reducing payments for low-quality care. Texas Medicaid plans to achieve these goals through the following mechanisms: program integrity monitoring through both internal and external processes, implementation of financial incentives for MCOs, and developing and implementing initiatives that encourage the use of evidence-based clinical and administrative practices by MCOs. The report cards are used to further the quality strategy goals of improving member satisfaction with care and emphasizing value-based purchasing.[f] • **Overview of plan-level quality initiatives:** In alignment with its quality strategy, Texas Medicaid also has the following quality initiatives for MCOs: – Texas Medicaid has a pay-for-performance program called Medical P4Q; it applies to the STAR, STAR+PLUS, STAR Kids, and CHIP. See the incentivizing plan performance section of the profile for more information about the P4Q program. – The EQRO conducts appointment availability studies for prenatal, primary care, vision, and behavioral health. Studies have been conducted on a rolling basis since 2015, with approximately two studies done each year.[f] – MCOs are required to submit to Texas Medicaid their plans for targeting beneficiaries with complex care needs, including intervention strategies and resources dedicated to care management of this group.[f] – Texas Medicaid initiated a contract provision into the managed care contracts that required that MCOs implement VBP models with providers and submit annual reports on their VBP activities.[f] – The Texas Healthcare Learning Collaborative portal is a secure web portal used byHHSC and their Medicaid contractors to track performance data on key quality of care measures. The data is interactive and can be queried to create more customized summaries of the quality results.[9] – The Performance Indicator Dashboards include a series of measures that identify key aspects of performance to support MCO accountability. Dashboard measures include high- and minimum-performance standards by program. MCO program level performance on each measure is compared to the standards, and MCOs falling below minimum performance standards on one-third or more of the dashboard measures are subject to corrective action plans. – Health plans are required to conduct PIPs to examine and improve areas of service or care identified by HHSC in consultation with Texas's EQRO as needing improvement. Topics are selected based on health plan performance on quality measures and member surveys. HHSC requires each health plan to conduct two PIPs per program. One PIP per health plan must be a collaborative with another health plan, a Delivery System Reform Incentive Payment project, or a community-based organization.

[9] Texas Health and Human Services Commission. Texas Healthcare Learning Collaborative Portal. https://thlcportal.com/home.

Quality Rating System design	
Link to QRS	The Texas managed care report cards can be accessed here: https://hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-members/managed-care-report-cards
History and evolution of QRS	• **History of the QRS:** The EQRO and Texas Medicaid began producing annual MCO report cards in 2013 to support the state's ongoing efforts to improve consumer choice in Texas Medicaid and CHIP. • **Evolution of the QRS:** The 2018 report card format changed from a three-star to a five-star rating, and the underlying methodology changed from percentile rating to cluster analysis rating. The decision to change the format and methodology was based on feedback from managed care plans, members, and a national review of other report card rating systems in use. The purpose of the report cards continues to be to provide newly enrolled Medicaid and CHIP members and their caregivers information to support selection of a managed care health plan. Texas Medicaid may develop report cards for dental services in the future. In addition, the report cards are a component of the new value-based enrollment.
Rating scales and benchmarks	• **Rating levels:** Ratings are calculated for each measure, domain, and overall health plan quality.[e] Ratings on each report card derive from a health plan's performance in a member's service area.[g] • **Rating scale:** Ratings for health plans are calculated using a five-star rating system, with five stars representing highest performance and one star representing lowest performance. See the section on scoring methodology and rules for more information.[g] – 5 stars: Highest performance(cluster with the highest mean ratings for the measure) – 4 stars: cluster with second highest mean ratings for the measure – 3 stars: cluster with the third highest mean ratings for the measure – 2 stars: cluster with the second lowest mean ratings for the measure – 1 star: Lowest performance(cluster with lowest mean ratings for the measure • **Rating benchmarks:** Ratings are calculated by comparing performance among all plan codes in a program (for example, CHIP plans are rated against CHIP plans, and adult Medicaid plans are rated against adult Medicaid plans).[g]
Quality measures used in the QRS	• **Domains:** Measures in the report card are divided into three domains for STAR Adult and STAR Child: – Experience of Care (4 CAHPS measures STAR Child; 5 CAHPS measures STAR Adult) – Staying Healthy (5 HEDIS measures) – Common Chronic Conditions (3 HEDIS measures STAR Child; 2 HEDIS measures STAR Adult) • **Measures:** The EQRO reports HEDIS administrative measures to the state. The EQRO used a subset of 23 of those measures to calculate the report card ratings for the comprehensive MCOs (that is, STAR Child and STAR Adult).[g] Some of the 23 QRS measures were also FFY 2020 Medicaid Core Set measures. The domains on the report card are made up of multiple HEDIS or CAHPS measures, and the indicators are presented in plain language descriptors. Please see Table E.1 for a detailed list of the measures included in Texas's QRS for the comprehensive MCOs.
Scoring methodology and rules	• **Responsibility for calculating ratings:** The EQRO calculates the ratings.[f]

Quality Rating System design	
	• **Methodology:** Each domain score is the equally weighted average of standardized individual items in the domain. Standardizing individual items for each base tier rescales the plan code scores so that 0 corresponds to the lowest-performing plan and 1 corresponds to the highest-performing plan. Standardized scores are put into an algorithm to determine domain and overall ratings. Score standardization for the overall composite score follows the same process. The EQRO uses *k*-means clustering to assign star ratings to plans based on similarities in performance, creating ratings that correspond to meaningful differences in performance (for example, plan codes must meet a minimum denominator threshold for HEDIS measures and survey responses and demonstrate statistical significance) that can help enrollees and caregivers distinguish between plans.[g]
Rating display and formats	• **Rating display:** Texas develops annual managed care report cards for each program by service area. Managed care report cards are posted on the Texas Medicaid website and are included in the Medicaid enrollment packets sent to eligible beneficiaries. A single instructions sheet for all report card types is available and serves as an introduction and guide to aid users of the report cards.[f] • **Format of QRS:** Ratings are presented in a PDF-based report card. To serve the diversity of Medicaid and CHIP enrollees, all report cards and the instructions sheet use language and presentation accessible for users with low numeracy or health-literacy, are available in both English and Spanish, and are published online as §508-compliant PDF files.[e] • **Plan changes over time**: There is no indication of change in plan performance over time in the QRS. • **New plans:** If an MCO plan was new to the area at the time of the study or if the plan did not have enough information to rate, the report card rates the plan "No Rating."[e] • **Frequency of rating updates**: The report cards are produced each year using administrative data from two calendar years prior and use the most recent iteration of member/caregiver surveys.[g] The current report cards were published in March 2020.
Stakeholder engagement in QRS development and updates	• The EQRO and Texas Medicaid select measures for the QRS based on Texas Medicaid priorities, prevalence of each measure, MCO historical performance, NCQA updates, and feedback from stakeholders. The measures are shared with the MCOs and with statewide advisory committees that include providers, MCOs, members, and advocates. Final recommendations for specific measures and methods for ratings on the MCO report cards balance NCQA and CMS standards for evaluating quality of care with agency priorities, MCO performance, and stakeholder feedback. Report cards are published annually.[g]
Quality Ratings Systems uses	
Informing beneficiary choice	• In addition to QRS report cards, beneficiaries have access to tools to allow them to see a list of providers and clinics for each plan and value-added service charts, which describe extra services (such as 24-hour nurse lines) that may be included in the plan.[i] The report cards include a link to the Texas Healthcare Learning Collaborative portal as an additional resource to learn about each health plan's performance.
Incentivizing plan performance	• **Auto-assignment:** Previously, the MCO default enrollment methodology that auto-assigns beneficiaries to a managed care plan was not tied to quality performance. It considered the percentage of beneficiaries actively choosing an MCO, the beneficiary's established history with an MCO or a primary care provider,, the geographic proximity of that provider to the beneficiary residence, and whether the provider sees other members of the

Quality Ratings Systems uses	
	beneficiary's household.[j] The 2020-21 General Appropriations Act, House Bill 1, 86th Legislature, Regular Session, 2019, Article II, HHSC, Rider 43 requires Texas to create an incentive program to automatically enroll a greater percentage of Medicaid recipients who have not selected a managed care plan into plans based on quality of care, efficiency and effectiveness of service provision, and performance. HHSC implemented this incentive program on September 1, 2020. The new model continues to include the facets described above while adding a quality/value component. The number of individuals impacted by this process will vary by month. For the state's largest Medicaid program, STAR, approximately 29,000 beneficiaries did not choose a plan in January 2020 and were auto-enrolled, compared to 26,400 who actively made a plan selection. An additional 75,500 beneficiaries were enrolled in a plan through restorative enrollment, retro enrollment, or other auto-assignment methods. • **Pay-for-performance:** Texas' P4Q Program provides financial incentives and disincentives to MCOs and DMOs based on performance on quality measures as required by Texas Government Code Section 536.051. This program was implemented in 2014, and it applies to the STAR, STAR+PLUS, CHIP, Children's Medicaid Dental Services, and CHIP Dental programs.[f,h10] – The medical and dental P4Q programs places three percent of MCO and 1.5 percent of DMO capitation at risk, respectively. Texas Medicaid assesses the MCO performance on quality measures based on performance against benchmarks, performance against self, and a bonus pool.[h] Because dental measures do not have national benchmarks, the DMOs are assessed only on performance against self. o The P4Q program was redesigned in 2018[f] o Funds recouped from MCOs or DMOs for poor performance are redistributed to MCOs or DMOs that performed well within the same program. o No medical P4Q funds are returned to the state. Dental P4Q funds may be returned to the state depending on plan performance. – There is some alignment with Texas's QRS and the medical P4Q program. Of the 14 at-risk measures in the medical P4Q program, 7 of them are also used in Texas's QRS (6 HEDIS measures, 1 CAHPS measure). Of the 16 measures in the bonus pool of the medical P4Q program, 9 of them are also used in Texas's QRS (4 HEDIS, 3 CAHPS, and 2 National Survey of Children with Special Health Care Needs measures). Please see Appendix A for a detailed list of the measures in the QRS and their overlap with Texas's other quality incentive programs. Measures are evaluated and selected every two years with changes made annually to adapt to measure modifications and/or plan performance.[f]
Conducting plan oversight	• **Demographic information:** Texas obtains race, ethnicity, and primary language spoken by a member from the enrollment form completed by that member. The EQRO has developed questions to obtain demographic and household information as part of the CAHPS member and caregiver surveys.[f] While the MCO report cards are stratified by age (adult versus child) and geography (service areas), many of the underlying measures can be viewed on the Texas Healthcare Learning Collaborative portal (thlcportal.com) by additional demographic categories, including sex, race/ethnicity, and health status. • **Other measures for plan oversight:**

[10] Texas Medicaid intended to include STAR Kids in the P4Q program in CY 2020. However, the program was suspended due to COVID-19. Consequently, STAR Kids has not been added to the P4Q program.

Quality Ratings Systems uses	
	– Texas employs Performance Indicator Dashboards on the Texas Healthcare Learning Collaborative portal (thlcportal.com). The dashboards include a series of measures that identify key aspects of performance and associated targets to support transparency and MCO accountability.[f] o There is strong alignment between Texas' QRS and the Performance Indicator Dashboards.[g] For example, of the 57 Performance Indicator Dashboard measures in STAR, 19 measures are also used in the state's QRS (4 CAHPS and 15 HEDIS). Please see Appendix A for a detailed list of the measures in the STAR QRS and their overlap with Texas's other quality incentive programs. – In addition to measures included in the QRS, the EQRO runs 3M PPE measures. PPEs are used in many of Texas's quality programs, including value-based enrollment and Medical P4Q.[g] • **Oversight mechanisms:** At this time, there are no contractual remedies (such as liquidated damages or corrective action plans) associated with the report card star ratings. As mentioned above, report card ratings are a component of the state's value-based enrollment initiative.

[a] Medicare Payment Advisory Commission (MedPAC). 2019. Program enrollment and spending: Medicaid managed care. https://www.macpac.gov/macstats/medicaid-managed-care/.

[b] Kaiser Family Foundation. 2019. Share of Medicaid population covered under different delivery systems. https://www.kff.org/medicaid/state-indicator/share-of-medicaid-population-covered-under-different-delivery-systems/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[c] Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2017. Medicaid managed care enrollment report: Managed care enrollment by program and plan. https://data.medicaid.gov/Enrollment/Managed-Care-Enrollment-by-Program-and-Plan/ghyh-r8nn/data.

[d] Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018. Medicaid managed care enrollment report: 2018 managed care enrollment by program and plan. https://data.medicaid.gov/Enrollment/2018-Managed-Care-Enrollment-by-Program-and-Plan/5gyf-8cgz/data.

[e] Texas Department of Health and Human Services. 2020. Managed care report cards.

https://hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-members/managed-care-report-cards.

[f] Texas Department of Health and Human Services. 2017. Texas Healthcare Transformation and Quality Improvement Program: Quality Improvement Strategy. Austin, TX: Texas Department of Health and Human Services. https://clpc.ucsf.edu/sites/clpc.ucsf.edu/files/TX%20Managed%20Care%20Quality%20Improvement%20Strategy%202017.pdf.

[g] Texas Department of Health and Human Services and Texas External Quality Review Organization. 2018. Summary of activities and value-added services: State fiscal year 2018. Austin, TX: Texas Department of Health and Human Services.

https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/eqro-summary-of-activites-report-contract-yr-2018.pdf.

[h] Texas Department of Health and Human Services. 2020. HHSC uniform managed care manual: Medical Pay for Quality (P4Q) Program. Austin, TX: Texas Department of Health and Human Services. https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/6-2-14.pdf.

[i] Texas Department of Health and Human Services. 2020. Choosing a health plan. https://hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-members/choosing-a-health-plan.

[j] Texas Administrative Code. 2014. Rule § 353.403: Medicaid managed care enrollment and disenrollment.

https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=1&pt=15&ch=353&rl=403.

CAHPS = Consumer Assessment of Healthcare Providers and Systems; CHIP = Children's Health Insurance Program; CMS = Centers for Medicare & Medicaid Services; DMO = dental maintenance organization; DSRIP = Delivery System Reform Incentive Payment Program; EQRO = External Quality Review Organization; HEDIS = Healthcare Effectiveness Data and Information Set; HHSC = Health and Human Services Commission; MCO = managed care organization; MLTSS = Managed Long-Term Services and Supports; NCQA = National Committee for Quality Assurance; PAHP = Prepaid Ambulatory Health Plan; PIP = performance improvement project; PPC = potentially preventable complications; PPE = potentially preventable events; PPR = potentially preventable readmissions; P4Q = pay for quality; QIPP = Quality Incentive Payment Program; QRS = Quality Rating System; SFY = State Fiscal Year; THLC = Texas Healthcare Learning Collaborative; VBP = value-based purchasing.

Table E.1. Alignment of Texas QRS measures with other quality initiatives as of August 2020

Measures	FFY 2020 Child or Adult Core Set measure[a]	2018 "At-Risk" measure in Medical Pay for Quality Program[b]	2018 Bonus Pool measure in Medical Pay for Quality Program[b]	Used in Performance Indicator Dashboard[c]	Measure data source
STAR Child					
Experience of Care domain					
Getting Care Quickly	X			X	CAHPS
How Well Doctors Communicate	X			X	CAHPS
Rating of Personal Doctor	X			X	CAHPS
Rating of Health Plan	X			X	CAHPS
Staying Healthy domain					
Well-Child Visits in First 15 Months of Life	X			X	HEDIS
Well-Child Visits in Third, Fourth, Fifth, and Sixth Years of Life	X			X	HEDIS
Adolescent Well-Care Visits	X			X	HEDIS
Childhood Immunization Status	X			X	HEDIS
Immunizations for Adolescents	X				HEDIS
Common Chronic Conditions domain					
Asthma Medication Ratio	X			X	HEDIS
Medication Management for People with Asthma				X	HEDIS
Follow-Up Care for Children Prescribed ADHD Medication	X			X	HEDIS
Non-QRS measures (used in Pay for Quality Program only)					
Potentially Preventable Emergency Department Visits				X	
Appropriate Treatment for Children with Upper Respiratory Infection				X	
STAR Adult					
Experience of Care domain					
Getting Care Quickly	X			X	CAHPS

Measures	FFY 2020 Child or Adult Core Set measure[a]	2018 "At-Risk" measure in Medical Pay for Quality Program[b]	2018 Bonus Pool measure in Medical Pay for Quality Program[b]	Used in Performance Indicator Dashboard[c]	Measure data source
Getting Needed Care	X			X	CAHPS
How Well Doctors Communicate	X			X	CAHPS
Rating of Personal Doctor	X			X	CAHPS
Rating of Health Plan	X		X	X	CAHPS
Staying Healthy domain					
Prenatal and Postpartum Care, timeliness of prenatal care	X	X		X	HEDIS
Prenatal and Postpartum Care, postpartum care	X	X		X	HEDIS
Adults' Access to Preventive/Ambulatory Health Services					HEDIS
Cervical Cancer Screening	X			X	HEDIS
Common Chronic Conditions domain					
Antidepressant Medication Management	X			X	HEDIS
Comprehensive Diabetes Care				X	HEDIS
Non-QRS measures (used in Pay for Quality Program only)					
Potentially Preventable Admissions			X	X	3M
Follow-Up Care for Children Prescribed ADHD Medication	X			X	HEDIS
Low Birth Weight			X	X	CMS
Childhood Immunization Status	X			X	HEDIS
Good Access to Urgent Care			X	X	CAHPS
Potentially Preventable Emergency Department Visits		X		X	3M

[a] Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020. Adult and Child Health Care Quality Measures. https://www.medicaid.gov/medicaid/quality-of-care/quality-of-care-performance-measurement/adult-and-child-health-care-quality-measures/index.html.

[b] Texas Department of Health and Human Services. 2020. HHSC uniform managed care manual: Medical Pay for Quality (P4Q) Program. Austin, TX: Texas Department of Health and Human Services. https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/6-2-14.pdf.

[c] Texas Department of Health and Human Services. 2020. Texas DSRIP Measure Bundle Protocol demonstration years 7–10. https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/1115-medicaid-waiver-tools-guidelines-regional-healthcare-partnership-participants/dy7-10-final-mbp.pdf.

ADHD = attention deficit hyperactivity disorder; CAHPS = Consumer Assessment of Healthcare Providers and Systems; DSRIP = Delivery System Reform Incentive Payment; FFY = federal fiscal year; HEDIS = Healthcare Effectiveness Data and Information Set; MY = measurement year; QRS = Quality Rating System.

Appendix F:
Medicare Advantage QRS Profile

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MEDICARE ADVANTAGE

The Centers for Medicare & Medicaid Services (CMS) publishes information on the quality performance of Medicare Advantage and Prescription Drug Plans each year as part of its five-star Quality Rating System. CMS awards star ratings to plans based on their performance on a number of clinical quality measures, as well as administrative and monitoring measures. Ratings are displayed on the Medicare Plan Finder website, which beneficiaries can use to review plans and select the one that best fits their needs.

Overview of the managed care environment	
Market overview	• **Total enrollment in Medicare managed care:** As of May 2020, almost 24.8 million Medicare beneficiaries were enrolled in MA; this represents nearly 40 percent of all Medicare beneficiaries.[a] • **Managed care organizations:** In 2019, the following seven national for-profit firms made up 81 percent of the MA market share nationwide.[b, c] – UnitedHealthcare: 26 percent – Humana: 18 percent – Blue Cross Blue Shield and affiliates: 15 percent – CVS/Aetna, Kaiser Permanente, Wellcare, and Cigna: 22 percent • **Plan performance:** Approximately 81 percent of enrollees are currently in MA plans with drug coverage that have a 4- or 5-star rating for 2020.[c] • **Geographic service area:** MA plans are contracted to provide services either at the local (county) or regional level. There are 26 MA regions nationwide.[d] • **Types of plans offered:** Health Maintenance Organization, Preferred Provider Organization, PFFS, SNPs, and HDHPs (referred to as 'Medicare Medical Savings Account Plans').[e]
Populations and conditions covered in the QRS	• MA (also known as Medicare Part C) covers all original Medicare (also known as Medicare Part A and Part B) services, as well as emergency and urgent care visits for enrollees over the age of 65, individuals with disabilities, and beneficiaries dually eligible for Medicare and Medicaid. With the exception of HDHPs and PFFS plans, MA plans include Medicare prescription drug coverage (also known as Medicare Part D). Beneficiaries with HDHPs and PFFS plans may join a separate Medicare PDP. Some plans cover vision, hearing, dental, and other plan-specific health and wellness programs.[e] • The MA SNPs cover additional services for beneficiaries with a chronic condition, such as autoimmune disorders, cancer, congestive heart failure, and stroke. [e]
Quality initiatives in Medicare Advantage	• **Overall strategy:** MA's quality strategy provides plans with a framework of quality improvement topic areas in the following domains: (1) Safer Patient Care, (2) Patient-Centered Care, (3) Effective Care Coordination, (4) Effective Prevention & Treatment, (5) Promotion of Healthy Living, (6) Effective Communication, and (7) Improving Affordability. These domains reflect the priorities of the Health and Human Services National Quality Strategy and the domains in the Institute of Medicine quality of care report, "Crossing the Quality Chasm."[g] • **Overview of other plan-level quality initiatives:** MA plans are required to conduct Chronic Care Improvement Program (CCIP) initiatives. They are required to the report the status of their CCIPs to CMS by December 31 of each year.[h]

Overview of the managed care environment	
Payment arrangements for MA plans	• MA benchmarks are determined locally, based on several county-level factors (such as the relationship between a county's per capita Medicare fee-for-service program expenditures and the national average level of fee-for-service program expenditures). County benchmarks are set at one of four quartile levels. The benchmark is 95, 100, 107.5 or 115 percent of the fee-for-service projected rate for that county for the year. The quartile assignment depends on expenditure levels during the preceding year.[l] • The MA plan bids are compared to the benchmarks of the county where the plan is offered. If a plan bids below the benchmark, it retains a portion (a rebate) of the difference between its bid and the benchmark. Rebates can be used to provide extra benefits for beneficiaries, such as reduced cost sharing or enhancing the plan's prescription drug coverage. If a plan bids above the benchmark, it must charge a premium to the enrollee. Plan payments are risk adjusted based on the health status of each beneficiary.[l] • Under the Quality Bonus Program (pay-for-performance program), MA plans with four or more star ratings are eligible to receive bonus payments added to the benchmark levels.[g]
Quality Rating System design	
Link to QRS	The Medicare Advantage Plan Finder can be accessed here: https://www.medicare.gov/plan-compare/#/?lang=en
History and evolution of QRS	• The MA QRS was introduced in 2007 as a way to encourage consumers to enroll in high-quality MA plans, with the first star ratings publicly reported in 2009.[o] • In 2011, an overall plan rating was added to the methodology, which already included the domain and measure-level ratings.[o] • Beginning in 2014, MA plan payments were tied to plan performance on the QRS. Since then, overall plan ratings have increased and the subset of quality measures in the QRS have remained largely consistent. The overall star rating is the weighted average of all the measures a plan can report (a plan must report at least half of the measures). [o]
Rating scales and benchmarks	• **Rating levels:** The MA QRS uses a five-category rating scale to calculate star ratings at four different levels for each plan, including (1) an overall star rating, (2) a summary rating for Part C and Part D individually, (3) a domain-level rating, and (4) a measure-level rating. CMS assigns whole- and half-star ratings for the overall and summary ratings to allow for greater variation in plan performance.[j] • **Rating scale:** CMS uses a the following five-star rating scale:[j] – 5 stars: Excellent – 4 stars: Above average – 3 stars: Average – 2 stars: Below average – 1 star: Poor • **Rating benchmarks:** Star ratings are based on plan performance compared to all other plans nationally.[j] See the methodology section for more information on the steps to calculate the star ratings.

Quality Rating System design	
Quality measures used in the QRS	• **Domains and measures:** The 2020 QRS includes 46 measures across 9 domains related to clinical quality, patient experience, and administrative performance (33 measures across 5 domains in Part C and 14 measures across 4 domains in Part D). Plans without prescription drug coverage are rated on up to 33 measures, and stand-alone prescription drug plans are rated on up to 14 measures. Plans are required to report at least half of the measures to receive a star rating. Please refer to Table F.1 for the measures in each domain and their primary data source (HEDIS, CAHPS, CMS).[j] The nine domains are listed below: – Staying Healthy: Screenings, Tests, and Vaccines (7 measures) – Managing Chronic (Long-Term) Conditions (14 measures) – Member Experience with Health Plan (6 measures) – Member Complaints and Changes in the Health Plans Performance (3 measures) – Health Plan Customer Service (3 measures) – Drug Plan Customer Service (3 measures) – Member Complaints and Changes in the Drug Plans Performance (3 measures) – Member Experience with the Drug Plan (2 measures) – Drug Safety and Accuracy of Drug Pricing (6 measures)
Scoring methodology and rules	• **Responsibility for calculating measures**: CMS is responsible for calculating and updating the star ratings each year.[j] • **Methodology:**[j] For most of the measures in the MA QRS, the threshold (or cut point) for assigning performance results for each of the five-star rating levels is determined through a tournament model. Under this model, plans are measured against each other's performance, not against a set performance target. For each measure, an MA plan receives a score from one to five stars. The domain-level rating is the average, unweighted mean of the measure-level stars in that domain. The summary and overall star ratings are calculated as weighted averages of the measure-level stars. Process measures have a weight of 1, access and patient experience measures have a weight of 2, outcome measures have a weight of 3, and the two improvement measures that CMS computes have a weight of 5. In a measure's first year of inclusion in the QRS, it is given a weight of 1; in subsequent years, the measure is weighted according to its category. CMS may adjust the weights based on recommendations from stakeholders, providers, technical and industry experts, and internal audits and reviews. – All plans are required to report all the measures; if they do not report at least half of the measures, they do not receive a rating. – Each year, plans fall into five groups according to their performance results, with the highest rated at 5 stars and the lowest at 1 star. Under this system, the cut points that determine the groupings will vary from year to year, thus producing shifting performance targets. Cut points are established using two different methodological adjustments: clustering or relative distribution and significance testing. The clustering approach is used to set cut points for the majority of the measures, while relative distribution and significance testing is used for the CAHPS measures.

Quality Rating System design	
	– Two adjustments are made to the ratings. The first is a reward factor, which rewards plans that have both high and stable performance. The second is a categorical adjustment index, which adjusts for the plan's percentage of beneficiaries who are dually eligible or have disabilities.
Rating display and formats	• **Rating display and format of the QRS:** MA uses a web-based interactive platform called the Medicare Plan Finder, where users have the option to view the plans offered in the zip code where they reside.[i] • **New plans**: New plans must have sufficient data to be included in the QRS. New plans without enough data in at least half of the measures are labeled "Plan too new to be measured" on the QRS. For example, a contract that begins in 2020 will first get a rating for the 2022 MA star ratings. If the contract does not have enough data for the 2022 ratings, it will be noted that it does not have enough data and treated as a low enrollment contract for payment purposes.[j] • **Data issues:** For any measures that CMS identifies to be based on missing, inaccurate, or biased data, CMS reduces the plan's measure-level rating to 1 star and reports that "CMS identified issues with this plan's data." For issues with appeals measures, the reduction to the star rating is scaled (not automatically reduced to 1 star).[j] • **Changes over time**: The QRS includes measures of improvement from the prior year for both Part C and Part D plans. Plans with consistently high or low performance receive the 'high performing indicator' or the 'low performing indicator.'[i] See the methodology section above for more information on these indicators. • **Frequency of rating updates:** The ratings are updated every October, in time for the annual MA enrollment period from October to December. Generally, ratings reflect plan performance in the previous calendar year.[j]
Stakeholder engagement in QRS development and updates	• **Stakeholder feedback:** CMS convened a technical expert panel in 2018 and 2019 to advise on enhancements to the star rating system. The panel was made up of individuals with expertise in quality measurement, risk adjustment, statistical methods, and MA. Each year, CMS conducts a comprehensive review of the measures that make up the star ratings by assessing the reliability of the data, clinical recommendations, and feedback received from stakeholders. Each year, CMS has released a request for public comment in response to any proposed changes to the star rating methodology.[k]
Quality Ratings Systems uses	
Informing beneficiary choice	• Beneficiaries using Medicare Plan Finder to review plans can select a 'details' button for each plan, which displays the QRS; beneficiaries are able to view domain-level and measure-level ratings for each plan. Each plan offers details of benefits in addition to monthly premiums in the beneficiary's county of residence, yearly drug and premium costs, and other costs (such as health deductibles and maximum amount a beneficiary would pay for in-network health services). It also displays the plan benefits (such as, vision, dental, hearing, transportation, fitness benefits, worldwide emergency, and telehealth) and copay amount per visit for primary care and specialist care. The plans displayed can be sorted by (1) lowest drug and premium cost, (2) lowest monthly premium, (3) lowest yearly drug deductible, and (4) lowest health plan deductible. The platform also allows users to compare their drug costs among plans.[i] • Plans that receive either a five-star overall rating receive a high-performing icon on Plan Finder to indicate the plan received Medicare's highest rating. Plans with consistent low performance (for example, summary ratings of 2.5 stars or lower during the previous three years) receive a low-performing icon on Plan Finder.[i,j]

Quality Ratings Systems uses	
	• MA plans must provide their star ratings information in plan marketing materials. New plans that do not yet have ratings are not required to provide this information until ratings are available.[m]
Incentivizing plan performance	• Plans that receive four- or five-star ratings are eligible for bonus payments. These bonus payments can increase the plan benchmark by up to 5 percent. Highly rated plans in counties with low fee-for-service expenditures and high Medicare managed care enrollment are eligible to have their bonuses doubled.[f] • The Medicaid Payment Advisory Commission estimates that bonus payments account for 2 to 3 percentage points of all MA spending in 2020.[f] • Five-star rated plans may enroll beneficiaries at any time during the year. If a beneficiary is enrolled in a low-performing icon plan, they are eligible for a special enrollment to enroll in a higher performing plan.[j]
Conducting plan oversight	• **Oversight mechanisms:** CMS regularly audits MA plans to ensure compliance with contractual requirements. If audits find that plan non-compliance may have impacted the calculation of a measure, the measure may be reported as inaccurate or biased. Further, if plans do not submit their patient-level data files by the submission deadline, the measure-level ratings are all reduced to 1 star.[j] – The QRS includes several monitoring measures related to member complaints and appeals in two domains: (1) Member Complaints and Changes in the Health Plans Performance and (2) Health Plan Customer Service. • **Enforcement actions:** CMS uses three primary enforcement actions in conducting MA plan oversight: (1) civil money penalties; (2) intermediate sanctions, like the suspension of marketing, enrollment, or payment; and (3) termination of the plan from the MA program. CMS publishes a list of plans that have been subject to these enforcement actions on its website, separate from the QRS so beneficiaries would need to navigate away from the QRS platform to find this information.[n] – As of October 2020, there is one MA plan identified on Plan Finder with a low performance warning for consistently low quality ratings. Plans in this category receive a Warning Letter for Part C and/or Part D summary ratings of 2.5 or fewer stars from at least 2018 through 2020. A Warning Letter is a formal communication that describes the consequences of continued non-compliance. Should an issue(s) persist, the warning level may be escalated to require a written response and business plan from the MA plan.[k]

[a] Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020. Medicare enrollment dashboard. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/Dashboard.

[b] Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020. Medicare Advantage enrollment by state, county, contract. https://www.cms.gov/research-statistics-data-and-systemsstatistics-trends-and-reportsmcradvpartdenroldatamonthly-ma/ma-enrollment-scc-2020-06.

[c] Kaiser Family Foundation. 2020. A dozen facts about Medicare Advantage in 2019. https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2019/.

[d] Kaiser Family Foundation. 2005. Profile and analysis of the 26 Medicare Advantage regions. https://www.kff.org/medicare/issue-brief/profile-and-analysis-of-the-26-medicare/.

[e] Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019. Understanding Medicare Advantage plans. https://www.medicare.gov/Pubs/pdf/12026-Understanding-Medicare-Advantage-Plans.pdf.

[f] Medicare Payment Advisory Commission (MedPAC). 2019. Redesigning the Medicare Advantage quality bonus program. In *Report to Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC. http://www.medpac.gov/docs/default-source/reports/jun19_ch8_medpac_reporttocongress_sec.pdf.

[g] Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2012. Medicare Advantage and Medicare Prescription Drug Plan Quality Strategy: A framework for improving care for beneficiaries. https://www.cms.gov/Medicare/Health-Plans/Medicare-Advantage-Quality-Improvement-Program/Downloads/Quality_Strategy_061212.pdf.

[h] Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020. Medicare Advantage: Chronic Care Improvement Program resource document. https://www.cms.gov/files/document/cms-ma-ccip-resource-document-updated-2020.pdf-0.

[i] Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020. The 2021 Medicare Advantage plan finder. https://www.medicare.gov/plan-compare/#/?lang=en.

[j] Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019. Medicare 2020 Part C & D Star Ratings technical notes. https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/Star-Ratings-Technical-Notes-Oct-10-2019.pdf.

[k] Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019. 2020 Star Ratings fact sheet. Baltimore, MD: CMS. https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/2020-Star-Ratings-Fact-Sheet-.pdf.

[l] Medicare Payment Advisory Commission (MedPAC). 2018. Medicare Advantage program payment system. Washington, DC: MedPAC. http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_18_ma_final_sec.pdf?sfvrsn=0.

[m] Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019. Medicare communications and marketing guidelines. Baltimore, MD: CMS. https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Medicare_Communications_and_Marketing_Guidelines_Update_Memo_-_8-6-19.pdf.

[n] Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018. 2019 application cycle past performance review methodology final. Baltimore, MD: CMS. https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Downloads/2019ApplicationCyclePastPerformanceFinalMethodology.pdf.

[o] McKinsey & Company. 2018. Assessing the Medicare Advantage Star Ratings. https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/assessing-the-medicare-advantage-stars-ratings.

CAHPS = Consumer Assessment of Healthcare Providers and Systems; CCIP = Chronic Care Improvement Program; CMS = Centers for Medicare & Medicaid Services; HDHP = High-Deductible Health Plan; HEDIS = Healthcare Effectiveness Data and Information Set; MA = Medicare Advantage; PDP = Prescription Drug Plan; PFFS = private fee-for-service; QRS = Quality Rating System; SNP = Special Needs Plan.

Table F.1. Quality Ratings System (Star Ratings System) measures and source, plan year 2020

Medicare Advantage (Medicare Part C)	Measure data source
Staying Healthy: Screenings, Tests, and Vaccines	
Breast Cancer Screening	HEDIS
Colorectal Cancer Screening	HEDIS
Annual Flu Vaccine	CAHPS
Improving or Maintaining Physical Health	CMS Health Outcomes Survey
Improving or Maintaining Mental Health	CMS Health Outcomes Survey
Monitoring Physical Activity	HEDIS / CMS Health Outcomes Survey
Adult BMI Assessment	HEDIS
Managing Chronic (Long-Term Conditions)	
SNP Care Management	CMS Part C Plan Reporting
Care for Older Adults - Medication Review	HEDIS
Care for Older Adults - Functional Status Assessment	HEDIS
Care for Older Adults - Pain Assessment	HEDIS
Osteoporosis Management in Women who had a Fracture	HEDIS
Diabetes Care - Eye Exam	HEDIS
Diabetes Care - Kidney Disease Management	HEDIS
Diabetes Care - Blood Sugar Controlled	HEDIS
Rheumatoid Arthritis Management	HEDIS
Reducing the Risk of Falling	HEDIS / CMS Health Outcomes Survey
Improving Bladder Control	HEDIS / CMS Health Outcomes Survey
Medication Reconciliation Post-Discharge	HEDIS
Plan All-Cause Readmissions	HEDIS
Statin Therapy for Patients with Cardiovascular Disease	HEDIS
Member Experience with Health Plan	
Getting Needed Care	CAHPS
Getting Appointments and Care Quickly	CAHPS
Customer Service	CAHPS
Rating of Health Care Quality	CAHPS
Rating of Health Plan	CAHPS

Medicare Advantage (Medicare Part C)	Measure data source
Care Coordination	CAHPS
Member Complaints and Changes in the Health Plans Performance	
Complaints about the Health Plan	CMS Complaints Tracking Module
Members Choosing to Leave the Plan	CMS Medicare Beneficiary Database Suite of Systems
Health Plan Quality Improvement	CMS Star Ratings
Health Plan Customer Service	
Plan Makes Timely Decisions about Appeals	Independent Review Entity
Reviewing Appeals Decisions	Independent Review Entity
Call Center - Foreign Language Interpreter and TTY Availability	CMS Call Center
Medicare Part D (Drug Plans)	**Measure data source**
Drug Plan Customer Service	
Call Center - Foreign Language Interpreter and TTY Availability	CMS Call Center
Appeals Auto-Forward	Independent Review Entity
Appeals Upheld	Independent Review Entity
Member Complaints and Changes in the Drug Plans Performance	
Complaints about the Drug Plan	CMS Complaints Tracking Module
Members Choosing to Leave the Plan	CMS Medicare Beneficiary Database Suite of Systems
Drug Plan Quality Improvement	CMS Star Ratings
Member Experience with the Drug Plan	
Rating of the Drug Plan	CAHPS
Getting Needed Prescription Drugs	CAHPS
Drug Safety and Accuracy of Drug Pricing	
MPF Pricing Accuracy	CMS Prescription Drug Event data, MPF Pricing Files
Medication Adherence for Diabetes Medications	CMS Prescription Drug Event
Medication Adherence for Hypertension (RAS antagonists)	CMS Prescription Drug Event
Medication Adherence for Cholesterol (Statins)	CMS Prescription Drug Event
MTM Program Completion Rate for CMR	CMS Part D Plan Reporting
Statin Use in Persons with Diabetes	CMS Prescription Drug Event

Source: Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019. Medicare 2020 Part C & D Star Ratings technical notes. https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/Star-Ratings-Technical-Notes-Oct-10-2019.pdf.

AHRQ = Agency for Healthcare Research and Quality; CAHPS = Consumer Assessment of Healthcare Providers and Systems; CMR = comprehensive medication review; CMS = Centers for Medicare & Medicaid Services; HEDIS = Healthcare Effectiveness Data and Information Set; MPF = Medicare Plan Finder; MTM = medication therapy management; NCQA = National Committee for Quality Assurance; PDE = prescription drug event; RAS = angiotensin system; TTY = teletype.

Appendix G:
Marketplace Qualified Health Plans QRS Profile

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MARKETPLACE QUALIFIED HEALTH PLANS

The Affordable Care Act required the establishment of a Quality Rating System (QRS) for Marketplace Qualified Health Plans (QHP) sold on the Federally-facilitated Exchanges (FFEs) and State-based Exchanges (SBEs) and required that these quality ratings be displayed on web-based platforms to assist individuals in the selection of a health insurance plan that best meets their needs. The Centers for Medicare & Medicaid Services (CMS) introduced the Marketplace QHP QRS in plan year 2017, with a limited display pilot test for plans in select FFE states. SBEs could choose to display quality ratings on their respective websites. As of plan year 2020, star ratings are calculated by CMS and publicly reported for all Marketplace QHPs on the FFE and SBEs.

Overview of the Marketplace environment	
Market overview	• **Total enrollment in Marketplace Qualified Health Plans:** As of January 2020, approximately 8.3 million people selected or were automatically re-enrolled in a Marketplace QHP during the 2020 open enrollment period. Approximately 2.1 million of the enrollees were new consumers, and the remaining 6.2 million were renewing coverage.[a] • **Issuers:** As of 2019, there were 208 issuers of Marketplace QHPs through the state-based and federally-facilitated Health Insurance Marketplaces. Issuers offering QHPs through the Marketplace in multiple states are counted once in each state in which they offer a QHP. Parent companies of issuers are counted in place of each subsidiary.[b] • **Plan performance**: In plan year 2019, 84 percent of consumers shopping on Healthcare.gov enrolled in a 3-, 4-, or 5-star plan. For plan year 2020, 93 percent of consumers shopping on HealthCare.gov have access to a 3-, 4-, or 5-star plan in their county.[c] • **Geographic service area**: In the 2020 benefit year, 38 states use the Healthcare.gov platform; this includes the FFE and SBEs on the federal platform (SBE-FP).[11] The remaining 13 states operate SBEs; these states are responsible for establishing and operating their own Marketplace websites.[a] • **Inclusion in QRS:** All QHPs on the Exchange (including the FFE, SBE-FPs, and SBEs on state-operated platforms) are subject to QRS and other certification requirements in order to offer plans on the Exchange. However, only those Marketplace QHPs that meet QRS eligibility and score requirements are included in the ratings calculations done by CMS.[d]
Populations and conditions covered	• **Eligibility:** Individuals who live in the United States, are U.S. citizens or nationals (or those who are lawfully present), and are not incarcerated are eligible to enroll in QHPs on the Marketplace. Individuals who have Medicare coverage are not eligible to enroll in a health or dental plan on the Marketplace.[e] • **Essential health benefits:** The Health Insurance Marketplace offers QHPs which provide EHBs, follow established limits on cost sharing, and meet other requirements under the Affordable Care Act. – All Marketplace QHPs must provide EHBs, as required by the Affordable Care Act. This includes services in the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health

[11] These states include Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

Overview of the Marketplace environment	
	treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.[f]
Quality initiatives for Marketplace Qualified Health Plans	• **Quality improvement strategy (QIS):** Marketplace QHPs that offer family and/or adult-only medical coverage through an Individual Exchange or the Small Business Health Options Program have been operating in an Exchange for two consecutive years and have more than 500 enrollees must implement a QIS, in accordance with the Affordable Care Act. The QIS is submitted as part of the Marketplace QHP certification application each year.[g] – A QIS is described as a payment structure that provides increased reimbursement or other market-based incentives for improving health outcomes of plan enrollees. – The strategy must address at least one of the following five topics: improve health outcomes, prevent hospital readmissions, improve patient safety and reduce medical errors, implement wellness and health promotion activities, and/or reduce health and health care disparities. The most common strategies submitted by issuers address diabetes treatment and cancer screenings. • **Patient safety standards:** As required by Section 1311(h)(1) of the Affordable Care Act, a Marketplace QHP may contract with hospitals with more than 50 beds only if they meet certain patient safety standards. These safety standards include the use of a patient safety evaluation system and a comprehensive hospital discharge program.[h] • **Value-based model:** In CMS's Proposed Payment Notice for 2021, CMS describes a new value-based model QHP, in which it encourages QHP issuers to consider consumer cost-sharing levels aimed at driving utilization of high-value services and lowering utilization of low-value services when medically appropriate. The final rule also makes it easier for QHP issuers to offer wellness incentives to enrollees by recognizing certain incentives as quality improvement activities.[i,j]
Payment arrangements for Marketplace QHP	• **Establishment of provider networks:** Plans contract directly with providers to establish their networks and set contracted rates for medical services. • **Availability of consumer subsidies:** The number of plan options varies by state and metro area, which impacts consumer choice. Marketplace QHPs are organized into four 'metal' categories (bronze, silver, gold, and platinum) depending on the level of cost sharing for the consumer. Subsidies are available through the Marketplace to consumers who meet certain income thresholds and do not have access to employer-sponsored health insurance.[k]
Quality Rating System design	
Link to QRS	• QRS star ratings are available for plans listed on the HealthCare.gov Exchange here: https://www.healthcare.gov/see-plans/#/ • SBEs are also required to publish QRS ratings on their respective websites.
History and evolution of QRS	• **Establishment of QRS:** In 2014, CMS finalized regulations for the Marketplace QHP QRS which required that, in order to be certified as a QHP, QHP issuers needed to submit clinical quality measure data and responses to an enrollee experience survey to CMS for the purpose of calculating star ratings.[d] • **Evolution of QRS:** CMS first publicly displayed QRS star ratings on Healthcare.gov for plan year 2017 for a limited number of pilot states, although ratings have been calculated each year for Marketplace QHPs across Exchanges

Quality Rating System design	
	since 2015. As of plan year 2020, star ratings are calculated and publicly reported for all eligible plans on the FFE and SBEs.[l]
Rating scales and benchmarks	• **Rating levels:** Ratings are calculated for individual reporting units at each level of the QRS hierarchy. The QRS hierarchy includes an overall global rating, 3 summary indicator ratings, 7 domain ratings, and 13 composite scores. CMS displays the overall rating and summary indicator ratings on HealthCare.gov.[d,m] – Composite scores are the average for a set of available measure scores. For example, the Behavioral Health composite score is the average of three measures: Antidepressant Medication Management, Follow-Up After Hospitalization for Mental illness (7-day Follow-Up), and Initiation and Engagement of Alcohol and Other Drug Dependence Treatment. These scores are not presented as star ratings in the QRS. – Domain ratings are assigned to a grouping of composite scores. For example, composite scores for Behavioral Health, Asthma Care, Cardiovascular Care, and Diabetes Care are averaged to yield a Clinical Effectiveness domain score. These scores are not presented as star ratings in the QRS. – Summary indicators are star ratings that reflect the average of multiple domain scores. For example, the Clinical Effectiveness, Patient Safety, and Prevention domain scores are averaged to calculate the Clinical Quality Management summary indicator. These indicators are presented as star ratings in the QRS. – The overall global rating is determined based on the sum of the summary indicator scores. The global ratings are presented as star ratings in the QRS. • **Rating scale:** Ratings are reported using a 5-star scale where 5 stars is the highest rating.[d,m] • **Rating benchmark:** Marketplace QHPs are rated against all other reporting QHPs nationally. CMS publishes benchmark values that show the standardized 5th, 10th, 25th, 50th, 75th, 90th, and 95th percentile values of the numerical rates for each measure across all eligible reporting units. Once scores are calculated for each component of the QRS hierarchy (that is, composites, domains, summary indicators, and overall), ratings are assigned based on cut points that delineate the five-star categories. The cut points change each year depending on plan performance; the cut points are available to Marketplace QHP issuers, but they are not publicly reported on the Exchanges.[d,m] – Separate from the QRS ratings, which are published on HealthCare.gov or SBE websites, CMS publishes measure-level and component-level scores for each Marketplace QHP. – National percentile rankings are also available in separate data files. See the section on rating display and formats for more information.
Quality measures used in the QRS	• **Summary indicators**: The Marketplace QHP QRS calculates and displays ratings for three summary indicators, as well as an overall quality rating. The summary indicators include (1) Member Experience, (2) Medical Care, and (3) Plan Administration. The summary indicators are calculated based on seven domain ratings, which include (1) Access and Care Coordination, (2) Doctor and Care, (3) Clinical Effectiveness, (4) Patient Safety, (5) Prevention, (6) Efficiency & Affordability, and (7) Plan Service. – The member experience summary indicator rating is calculated by averaging scores from two different domains: Access and Care Coordination and Doctor and Care. These domain scores are calculated from the averages of two composite scores: Access and Care Coordination and Doctor and Care, respectively. Each of these

Quality Rating System design	
	composite scores are calculated by averaging the measure scores from the QHP Enrollee Survey. The QHP Enrollee Survey is based on the CAHPS survey principles.[m] – The medical care summary indicator rating is calculated by averaging scores from three different domains: Clinical Effectiveness, Patient Safety, and Prevention. These domain scores are calculated from the averages of multiple composite scores. The Medical Care composite scores are based on the averages for several clinical quality measures. – The Plan Administration summary indicator rating is calculated by averaging scores from two different domains: Efficiency & Affordability and Plan Service. These domain scores are calculated from the averages of two composite scores: efficient care and enrollee experience with health plan, respectively. Each of these composite scores are calculated using the averages of a few monitoring and oversight measures, including the plan's customer service, access to needed information, and network providers ordering appropriate tests and treatment. • **Measures:** For 2020, the QRS measure set includes 37 measures. Each year, eligible Marketplace QHP issuers are required to report data for all QRS measures. Due to the removal of two NCQA measures and the addition of one PQA measure, Marketplace QHP issuers were required to submit data for 37 measures, but only 36 were to be used for QRS scoring in 2020. In response to the COVID-19 pandemic, CMS suspended data collection in 2020 and did not calculate 2020 QRS scores. – Some of the measures have multiple indicators/rates, including additional sub-levels (such as age bands). Marketplace QHP issuers are required to submit data for all parts of a measure, unless a specific indicator is listed (for example, for the Childhood Immunization Status [Combination 3] measure, only Combination 3 must be reported).[d] – AHRQ is the measure steward for eight measures, which use the QHP Enrollee Survey as the data source. NCQA is the measure steward for 27 measures; 25 of those measures use the administrative and/or hybrid method data, and 2 of those measures use the QHP Enrollee Survey as the data source. PQA is the steward for two measures, which use the administrative data method. See Table G.1 for a detailed list of the measures.[d]
Scoring methodology and rules	• **Responsibility for calculating ratings:** CMS is responsible for calculating quality ratings for all eligible QHPs in both the FFE and the SBEs.[d] – For a Marketplace QHP to receive QRS scores and ratings in 2020, a reporting unit must be in operation for three years—meaning that a Marketplace QHP issuer will only receive a 2020 QRS rating if it submitted measure data in 2018, 2019, and 2020.[d] – Measures that do not meet the minimum denominator threshold will also be excluded from scoring. The minimum denominator size is as follows for each type of measure: 30 observations for HEDIS clinical measures, 150 observations for the Planned All-Cause Readmissions measure, and 100 observations for the CAHPS survey measures.[d] • **Methodology:** The Marketplace QHP QRS uses a data-driven approach to provide sound, reliable, and meaningful quality-related information for consumers. CMS reports an Overall Rating and three summary indicators: Medical Care, Member Experience, and Plan Administration. Please see Table G.1 for a breakdown of the Marketplace QHP QRS summary indicators, domains, composites, measure titles, measure stewards, and data source.

Quality Rating System design	
	– To calculate standardized measure scores, the raw measure rates are transformed using z-standardization. The measure rate values of each reporting unit are compared to the mean measure rate using a national reference group. The spread is controlled using the standard deviation. – The QRS survey measures (excluding the two clinical measures from the QHP Enrollee Survey) and the QRS clinical measure Plan All-Cause Readmissions are case-mix adjusted.[d] – To calculate the composite measure scores, at least half of the associated measures must have a score. Then, the standardized measure scores are averaged to result in a composite measure score.[d] – To calculate the domain scores, at least half of the composite measures must have a score. Then, the composite measures are averaged to result in a domain score.[d] – To calculate the summary indicator ratings (that is, the Medical Care, Member Experience, and Plan Administration), at least half of the summary domains must have a score. Then, the domain scores are averaged to result in the summary indicator score.[d] – To calculate the Overall Score, CMS sums the weighted summary indicator scores. A weight of two-thirds is given to the Medical Care summary indicator and a weight of one-sixth is given to the Member Experience and Plan Administration summary indicators.[d] – The scores at the composite, domain, summary indicator, and overall level are converted to ratings using cut points. CMS uses four cut point values (to delineate the 5-star rating categories) based on clusters in the scores. These values are used to convert numeric scores into star ratings.
Rating display and formats	• **Rating display:** QRS ratings are posted on HealthCare.gov as star ratings that are displayed with other plan information when a potential enrollee examines Marketplace QHP options in their area. – For SBEs that do not use Healthcare.gov, quality ratings are required to be posted on their respective websites. However, SBEs are able to display and format the QRS ratings differently than the FFE. SBEs that display federally calculated QRS ratings must include disclaimer language to note that the ratings are based on data provided by health plans and calculated by the federal government. SBEs also will be given the flexibility to adjust the names of the QRS global rating and the summary indicator ratings. SBEs will also have the flexibility to display additional state or local quality information and to customize the display for their Marketplace QHP quality information.[m] – Marketplace QHP issuer and web-broker direct enrollment entities are required to display the federally calculated QRS ratings and use the CMS's consumer-facing labels. The quality rating information will be available through a public use file.[m] – Marketplace QHP issuers may utilize the QRS quality ratings and the QHP Enrollee Survey results in marketing materials, in accordance with CMS guidance.[m] • **QRS results for Marketplace QHP issuers:** CMS releases QRS Preview Reports and Proof Sheets that provide the measure-level results and scores and ratings for all QRS components (composites, domains, summary ratings, and the overall rating) to Marketplace QHP issuers. The reports are available online and for download as PDF files on the CMS Health Insurance Oversight System-Marketplace Quality Module website. Marketplace QHP issuers can download this information, which includes benchmark values for the standardized 5th, 10th, 25th, 50th,75th, 90th and 95th percentile values for the raw measure values across all reporting units.[d]

Quality Rating System design	
	• **New plans:** If a Marketplace QHP is not eligible for scoring (that is, it has not been in operation for at least three consecutive years), CMS will display "New plan – quality ratings unavailable" in the place of the Marketplace QHP quality rating information. • **Ineligible plans**: If a Marketplace QHP does not receive a rating for any other reason (for example, it did not meet the participation criteria or it did not receive a global score), CMS will display "Not Rated" in place of the QHP quality rating information.[m] • **Changes over time:** There is no indication of change in plan performance year over year on the HealthCare.gov platform.[n] • **Frequency of rating updates:** CMS calculates and updates Marketplace QHP QRS ratings annually in advance of the Open Enrollment period.[m]
Stakeholder engagement in QRS development and updates	• **Stakeholder feedback:** CMS seeks stakeholder feedback annually through the QRS and QHP Enrollee Survey Call Letter process as well as through Technical Expert Panels.[m] CMS also continuously refines the QRS program and the QHP Enrollee Survey based on stakeholder feedback, clinical guideline changes, administration priorities, and advances in quality measurement and survey administration. The CMS Office of Communications holds focus groups with consumers to test any planned changes to the Healthcare.gov interface, where the Marketplace QHP ratings are displayed.[d]
Other QRS design features	• QRS ratings became nationally available with the individual market open enrollment period starting November 1, 2019.
Quality Ratings Systems uses	
Informing beneficiary choice	• On HealthCare.gov, consumers have access to information about the Marketplace QHP's estimated monthly premium, deductible, out-of-pocket maximum, copayments/coinsurance, the "metal" category (bronze, silver, gold or platinum), plan features, access to doctors and hospitals, coverage for hospital services, medical management programs, and drug coverage.[n]
Incentivizing plan performance	• No plan performance incentive exists for FFE states, but states on the SBEs may implement their own incentive programs. Determining whether any SBEs have these incentive programs is outside the scope of this profile.
Conducting plan oversight	• Exchanges are responsible for Marketplace QHP certification and oversight of compliance with certification standards by Marketplace QHP issuers operating in their respective Exchanges.[d]

[a] Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020. 2020 Federal Health Insurance Exchange enrollment period final weekly enrollment snapshot. https://www.cms.gov/newsroom/fact-sheets/2020-federal-health-insurance-exchange-enrollment-period-final-weekly-enrollment-snapshot.

[b] Kaiser Family Foundation. 2019. Number of issuers participating in the Individual Health Insurance Marketplaces. https://www.kff.org/other/state-indicator/number-of-issuers-participating-in-the-individual-health-insurance-marketplace/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[c] Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020. Health Insurance Exchanges Quality Rating System (QRS) for plan year (PY) 2020: Results at a glance. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/Downloads/Health-Insurance-Exchanges-QRS-Program-for-Plan-Year-2020.pdf.

[d] Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019. Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical guidance for 2020. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/QRS-and-QHP-Enrollee-Survey-Technical-Guidance-for-2020-508.pdf.

[e] Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020. Are you eligible to use the Marketplace? https://www.healthcare.gov/quick-guide/eligibility/#:~:text=To%20be%20eligible%20to%20enroll,Learn%20about%20eligible%20immigration%20statuses.

[f] Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020. Information on essential health benefits (EHB) benchmark plans. https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.

[g] U.S. Department of Health and Human Services (HHS). 2020. Agency information collection activities: Proposed collection; Comment request; Quality Improvement Strategy Implementation Plan and progress report form. *Federal Register* 85, no. 86 (May 4): 26479–26480. https://www.govinfo.gov/content/pkg/FR-2020-05-04/pdf/2020-09452.pdf.

[h] Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. 2017. Patient safety standards. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/Patient-Safety/MQI-Patient-Safety

[l] Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018. About the Marketplace Quality Initiatives. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/About-MQI-Landing-Page.

[j] Keith, K. 2020. The 2021 Proposed Payment Notice, part 2: Exchange provisions. *Health Affairs Blog*, February 1. https://www.healthaffairs.org/do/10.1377/hblog20200201.566219/full/.

[k] Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020. CMS announces final Payment Notice for 2021 coverage year. May 7, 2020, press release. Baltimore, MD: CMS. https://www.cms.gov/newsroom/press-releases/cms-announces-final-payment-notice-2021-coverage-year.

[l] Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020. Saving money on health insurance. https://www.healthcare.gov/lower-costs/qualifying-for-lower-costs/.

[m] Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020. About the Quality Rating System (QRS). https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/Quality-Rating-System/About-the-QRS#:~:text=About%20the%20Quality%20Rating%20System,in%20consumer%20selection%20of%20QHPs.

[n] Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019. Quality Rating information bulletin. August 15, 2019. https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/QualityRatingInformationBulletinforPlanYear2020.pdf.

AHRQ = Agency for Healthcare Research and Quality; CAHPS = Consumer Assessment of Healthcare Providers and Systems; CMS = Centers for Medicare & Medicaid Services; EHB = essential health benefit; FFE = Federally-facilitated Exchange; HEDIS = Healthcare Effectiveness Data and Information Set; NCQA = National Committee for Quality Assurance; PQA = Pharmacy Quality Alliance; QHP = Qualified Health Plan; QIS = quality improvement strategy; QRS = Quality Rating System; SBE = State-based Exchanges; SBE–FP = State-based Exchange – Federal Platform.

Table G.1. Marketplace Qualified Health Plan QRS measure set, plan year 2020

QRS summary indicator	QRS domain	QRS composite	Measure title	Measure steward	Data source
Clinical Quality Management (Medical Care)	Clinical Effectiveness	Asthma Care	Medication Management for People With Asthma (75% of Treatment Period)	NCQA	Administrative data
		Behavioral Health	Antidepressant Medication Management	NCQA	Administrative data
			Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up)	NCQA	Administrative data
			Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA	Administrative data
		Cardiovascular Care	Controlling High Blood Pressure	NCQA	Hybrid method must be used
			Proportion of Days Covered (RAS Antagonists)	PQA	Administrative data
			Proportion of Days Covered (Statins)	PQA	Administrative data
		Diabetes Care	Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	NCQA	Administrative and hybrid
			Comprehensive Diabetes Care: Hemoglobin A1c Control (<8.0%)	NCQA	Administrative and hybrid
			Comprehensive Diabetes Care: Medical Attention for Nephropathy	NCQA	Administrative and hybrid
			Proportion of Days Covered (Diabetes All Class)	PQA	Administrative data
	Patient Safety	Patient Safety	International Normalized Ratio Monitoring for Individuals on Warfarin	PQA	Administrative data
			Plan All-Cause Readmissions	NCQA	Administrative data
	Prevention	Checking for Cancer	Breast Cancer Screening	NCQA	Administrative data
			Cervical Cancer Screening	NCQA	Administrative and hybrid
			Colorectal Cancer Screening	NCQA	Administrative and hybrid
		Maternal Health	Prenatal and Postpartum Care (Postpartum Care)	NCQA	Administrative or hybrid

QRS summary indicator	QRS domain	QRS composite	Measure title	Measure steward	Data source
			Prenatal and Postpartum Care (Timeliness of Prenatal Care)	NCQA	Administrative or hybrid
		Staying Healthy Adult	Adult BMI Assessment	NCQA	Administrative and hybrid
			Chlamydia Screening in Women	NCQA	Administrative and hybrid
			Flu Vaccinations for Adults Ages 18-64	NCQA	QHP Enrollee Survey
			Medical Assistance with Smoking and Tobacco Use Cessation	NCQA	QHP Enrollee Survey
			Annual Dental Visit	NCQA	Administrative data
		Staying Healthy Child	Childhood Immunization Status (Combination 3)	NCQA	Administrative and hybrid
			Immunizations for Adolescents (Combination 2)	NCQA	Administrative and hybrid
			Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	NCQA	Administrative or hybrid
			Well-Child Visits in the First 15 Months of Life (6 or More Visits)	NCQA	Administrative data
			Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	NCQA	Administrative data
Enrollee Experience (Member Experience)	Access and Care Coordination	Access and Care Coordination	Access to Care	AHRQ	QHP Enrollee Survey
			Care Coordination	AHRQ	QHP Enrollee Survey
			Rating of All Health Care	AHRQ	QHP Enrollee Survey
	Doctor and Care	Doctor and Care	Rating of Personal Doctor	AHRQ	QHP Enrollee Survey
			Rating of Specialist	AHRQ	QHP Enrollee Survey
		Efficient Care	Appropriate Testing for Pharyngitis	NCQA	Administrative data

QRS summary indicator	QRS domain	QRS composite	Measure title	Measure steward	Data source
Plan Efficiency, Affordability, & Management (Plan Administration)	Efficiency & Affordability		Appropriate Treatment for Upper Respiratory Infection	NCQA	Administrative data
			Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	NCQA	Administrative data
			Use of Imaging Studies for Low Back Pain	NCQA	Administrative data
	Plan Service	Enrollee Experience with Health Plan	Access to Information	AHRQ	QHP Enrollee Survey
			Plan Administration	AHRQ, CMS (measure consists of CAHPS survey item and developed for purposes of the QHP Enrollee Survey)	QHP Enrollee Survey
			Rating of Health Plan	AHRQ	QHP Enrollee Survey

Source: Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019. Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical guidance for 2020. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/QRS-and-QHP-Enrollee-Survey-Technical-Guidance-for-2020-508.pdf.

AHRQ = Agency for Healthcare Research and Quality; BMI = body mass index; CAHPS = Consumer Assessment of Healthcare Providers and Systems; CMS = Centers for Medicare & Medicaid Services; NCQA = National Committee for Quality Assurance; PQA = Pharmacy Quality Alliance; QHP = Qualified Health Plan; QRS = Quality Rating System; RAS = angiotensin system.

Appendix H:
Organizational Affiliation of Interviewees

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	Organizational affiliation
Florida	
State Medicaid officials	Florida Agency for Health Care Administration
Managed care organization	Staywell Health Plan of Florida
External quality review organization	N/A
Enrollment broker	Automated Health Systems
Beneficiary advocate	N/A
Michigan	
State Medicaid officials	Michigan Department of Community Health
Managed care organization	Blue Cross of Michigan
External quality review organization	Health Services Advisory Group
Enrollment broker	Michigan Enrolls
Beneficiary advocate	N/A
Ohio	
State Medicaid officials	Ohio Department of Medicaid
Managed care organization	United HealthCare
External quality review organization	IPRO
Enrollment broker	Automated Health Services Group
Beneficiary advocate	N/A
Pennsylvania	
State Medicaid officials	Pennsylvania Office of Medical Assistant Programs
Managed care organization	University of Pittsburgh Medical Center Health Plans
External quality review organization	IPRO
Enrollment broker	Maximus
Beneficiary advocate	N/A
Texas	
State Medicaid officials	Texas Health and Human Services Commission
Managed care organization	Texas Association of Community-Based Health Plans
External quality review organization	Institute for Child Health Policy
Enrollment broker	Maximus
Beneficiary advocate	Every Texan
National stakeholders	
Centers for Medicare & Medicaid Services	• Representatives from Center for Medicaid and CHIP Services • Representatives from Center for Quality Measures and Value-Based Incentives Group (Marketplace QHP QRS) • Representatives from the Center for Consumer Information and Insurance Oversight (Marketplace QHP QRS) • Representatives from the Division of Consumer Assessment and Plan Performance (MA QRS)
Managed care organizations	• Association for Community Affiliated Health Plans • America's Health Insurance Plans
Quality measure experts	National Committee for Quality Assurance
Beneficiary advocate	Families USA

N/A = Not applicable. No interviews were conducted in this category.

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