

# The Impact of Medicaid Quality Rating Systems on Consumer, Health Plan and Provider Behavior

OCTOBER 2016

## Contents

Introduction .....	2
From Quality Measurement to Quality Ratings.....	3
Federal Role in Medicaid Managed Care Quality.....	3
State Efforts to Drive Medicaid Managed Care Quality .....	4
Quality Rating Systems May Drive Quality Improvement .....	8
The Promise of Quality Rating Systems .....	9
Looking Forward: The Impact of Quality Ratings in the Future .....	12

## INTRODUCTION

### Content Highlight

While there is little evidence on the impact of Medicaid rating systems to date, the experience of quality rating systems for other populations, as well as growth of aligned quality improvement incentives, suggest that as Medicaid quality rating systems continue to evolve, so too could their impact on behavior and quality of care.

The health care quality movement is evolving from observing quality through measurement and reporting to refining systems that could drive the purchase, delivery, and utilization of higher value health care. One major part of this effort is the development of transparent and easily accessible health plan quality rating systems, intended to collectively impact consumer, health plan, and provider behavior. While their widespread use began among other populations, these rating systems are gaining traction as a tool to improve quality for comprehensive risk-based Medicaid managed care plans, as well.

Some state Medicaid programs have developed quality rating systems to help consumers more easily compare quality among health plans. The goal is to empower consumers to consider health plan quality when selecting a plan to ensure that a larger percentage of consumers opt for health plans that provide higher quality care. Health plans, in turn, would then be motivated to improve the quality of services they provide to attract and retain membership. They would likewise

work with their provider networks to emphasize and improve the quality of the services they provide.

As Medicaid managed care quality rating systems grow, there is widespread interest in whether these systems succeed in driving changes in consumer, health plan and provider behavior. The ability to drive this behavior change is complex, and influenced by a number of factors. On the consumer side, behavior change is predominantly influenced by the ability to present the information in ways that are comprehensible and relevant to consumers. Quality ratings are then considered alongside the consumer's other priorities and considerations related to health plan selection. On the health plan and provider side, behavior change and quality improvement efforts are motivated by linking the ratings with incentives such as pay-for-performance (P4P) programs.

Rating systems are likely to proliferate, with strong consumer engagement in health care and federal and state commitments to Medicaid managed care quality rating systems; for instance, newly finalized federal Medicaid managed care regulations require all states implement a quality rating system over the next three years.<sup>1</sup> While there is little evidence on the impact of Medicaid rating systems to date, the experience of quality rating systems for other populations, as well as growth of aligned quality improvement incentives (such as P4P), suggest that as Medicaid quality rating systems continue to evolve, so too could their impact on behavior and quality of care.



**Rating systems are gaining traction as a tool to improve quality for comprehensive risk-based Medicaid managed care plans.**

## FROM QUALITY MEASUREMENT TO QUALITY RATINGS

### Content Highlight

The efforts to organize and consolidate health plan-level performance measures into a relatively small set of ratings have taken the field of quality measurement a step further toward allowing consumers to digest and compare health plan quality.

The field of quality measurement in health care has garnered national attention since the early 2000s as the awareness of the gap between the science of health care—the proven, evidence-based medical care supported by research, and the practice of health care—the medical care that patients across the country are actually receiving, became apparent.<sup>2,3</sup> In response, the public, clinical leaders, policymakers, and other stakeholders called for improvements in the quality of care, along with a mechanism to assess those improvements. From this, the health care quality movement was born: payers and purchasers including health plans, employers, and federal and state government programs began measuring and reporting on quality while also introducing efforts to hold providers and plans accountable for meeting quality benchmarks. Over time, the resulting quality

measurement systems have been further refined with the intention of driving the purchase, delivery, and utilization of higher value health care.

While the proliferation of quality data offered new information on the quality of care across a range of health care services and conditions, it also “unleashed a multitude of uncoordinated, inconsistent, and often duplicative measurement and reporting initiatives,”<sup>4</sup> reducing the usefulness of the data for all interested audiences.

The full value of the multitude of quality measures and data points lies in the ability to synthesize these data in a way that is easily accessible for consumers and other stakeholders. Health plan quality rating systems attempt to combine a large amount of complex quality information into a limited number of “composite” reporting categories that are understandable and meaningful to consumers. The rating systems assign values (typically stars) to communicate a plan’s relative quality performance (e.g., high, medium, low) in a category. The efforts to organize and consolidate health plan-level performance measures into a relatively small set of ratings have taken the field of quality measurement a step further toward allowing consumers to digest and compare health plan quality.

Quality rating systems have taken a foothold in quality improvement programs across payers—particularly for Medicare and Qualified Health Plans (QHPs) established by the Affordable Care Act (ACA)—and are just now beginning to proliferate in comprehensive risk-based Medicaid managed care, as well.

## FEDERAL ROLE IN MEDICAID MANAGED CARE QUALITY

Federal Medicaid managed care regulations, promulgated in 2002, required states to develop comprehensive quality strategies that include certain required components but give states considerable flexibility in designing their own quality measurement systems. More recently, in April 2016, the Centers for Medicare & Medicaid Services (CMS) published final rules requiring states that enroll Medicaid beneficiaries in comprehensive, risk-based managed care to establish a quality rating system in the next three years. (A more detailed discussion of the new requirements can be found on the next page.)

Adding to the quality improvement efforts already underway in state Medicaid programs, ACA introduced broad legislation to bolster quality reporting and consumer use of data across all insurance types. Enacted in 2010, the ACA included multiple provisions to support consumers’ engagement in their health and health care provider choices, including increasing the availability of quality and resource use information through public reporting and the development of tools designed to assist

## The Medicaid Managed Care Quality Rating System

In April 2016, CMS released the first major overhaul of managed care regulations for Medicaid and the Children's Health Insurance Program (CHIP) in over a decade.<sup>5</sup> With respect to quality measurement and reporting, the rule requires states contracting with comprehensive risk-based Medicaid managed care organizations (MCOs) to develop and implement a quality rating system (QRS) over the next three years.

CMS expects to determine a core set of measures and corresponding methodology for all MCOs, as well as the structure and process of the overall rating system, through a three-year multi-stakeholder process that will include state Medicaid officials, health plans, consumer groups and experts in the quality and performance measurement field. At a minimum, CMS will develop a QRS that aligns with the methodology and indicators of the QHP quality rating system:<sup>6</sup> 1) clinical quality management; 2) member experience; and 3) plan efficiency, affordability, and management. According to the rule, states will be able to use an alternative methodology or adopt additional measures for use in the rating system, as long as it is "substantially comparable" to the QRS and is approved by CMS. The regulations also require that states "prominently display" the health plan ratings, ensuring that beneficiaries have access to the quality ratings at enrollment so that they can use them when choosing a health plan.

to consumers in choosing providers.<sup>7,8</sup> Under the direction of ACA, the National Quality Strategy and National Prevention Strategy were released in 2011 and identified consumer information and public reporting as key building blocks toward achieving the three-part aim (improved population health and experience of care, at lower per capita cost).<sup>9,10</sup> These strategies spur and provide direction for a nationwide quality improvement focus, and the three-part aim has been the backbone of numerous federal and state multi-payer quality reform efforts.

## STATE EFFORTS TO DRIVE MEDICAID MANAGED CARE QUALITY

### Content Highlight

Efforts to improve quality measurement and reporting on local, state and federal levels are underway, even as quality data are being used in and forming the basis for more advanced efforts to drive higher value health care, such as value-based purchasing and quality rating systems.

States have taken on various efforts to measure, promote and improve quality in their Medicaid managed care programs, including small number of states that have developed and are using quality rating systems.

### Quality Measurement

Many of the quality improvement efforts undertaken by states are based on overlapping sets of quality improvement measures. For instance, half of all states require Healthcare Effectiveness Data and Information Set<sup>®</sup> (HEDIS<sup>®</sup>)<sup>11</sup> and Consumer Assessment of Healthcare Providers and Systems<sup>®</sup> (CAHPS<sup>®</sup>) reporting of their Medicaid plans, which are nationally recognized and widely used measure sets.<sup>12</sup> More than a dozen states require that their Medicaid plans attain National Committee for Quality Assurance (NCQA)<sup>13</sup> Health Plan Accreditation in order to operate in the state,<sup>14</sup> which is largely based on documentation of standards and HEDIS<sup>®</sup> and CAHPS<sup>®</sup>

performance.<sup>15</sup> Federally required performance improvement projects (PIPs) may be based on topics that are state-required or plan-selected, but often include measures of HEDIS<sup>®</sup> and CAHPS<sup>®</sup> to assess performance.

While the use of these standardized measurement systems abound and quality measurement is growing, there are also noted gaps in measurement and challenges in collecting reliable and comparable Medicaid data.<sup>16</sup> Efforts to improve quality measurement and reporting on local, state and federal levels are underway, even as quality data are being used in and forming the basis for more advanced efforts to drive higher value health care, such as value-based purchasing and quality rating systems.



Half of all states require HEDIS<sup>®</sup> and CAHPS<sup>®</sup> reporting of their Medicaid plans.



More than a dozen states require that their Medicaid plans attain NCQA Health Plan Accreditation in order to operate in the state.

### Medicaid Managed Care Quality Rating Systems

Already, a number of states have their own quality rating systems while other states are in the process of developing their systems.<sup>17</sup> These ratings are provided to beneficiaries, often as part of a consumer guide, to aid in their selection of their health plan. Stars (or in the case of Michigan, apples) are used to indicate degrees of performance relative to state or national averages. Most states utilize a three-tiered system, where one star indicates below average, two stars indicate average, and three stars indicate above average performance. There are a few exceptions to this, such as New York and Kentucky, which use a five-star rating system.

Consistent with the range of quality measurement and reporting programs adopted across states, Medicaid managed care rating systems also vary widely in how they benchmark and report the results to consumers. For instance:

- Composite categories and global measures (e.g., access to care, management of chronic conditions) overlap but are not identical, and in some cases vary considerably.
- Some states do not report composites and global measures, and instead report individual measures under a composite heading (e.g., while Maryland reports a single “access to care” measure, Kentucky reports four separate measures related to access to care).
- Most states include measures related to both quality of care and patient satisfaction, though some states focus more heavily on one or the other.
- Some states base ratings on comparisons with other plans in the state, while others use national benchmarks for Medicaid health plans. For example, Ohio compares plans to its competitors within the state in order to ensure that not all plans are “above” or “below”, other states, such as Kentucky, determine the plans’ standings based on national averages.
- Some states also produce guides regionally (New York, Pennsylvania and Texas), while others provide a single guide to all Medicaid applicants and beneficiaries, including plans that may or may not be offered in their region of the state (Maryland, Michigan, Kentucky and Ohio), which could have the effect of guiding a consumer to a plan that isn’t available to him/her.

In addition to the Medicaid managed care ratings developed by individual states, NCQA provides two national-level cross-state quality rating tools—the Health Plan Report Card and Health Insurance Plan Ratings—that include Medicaid managed care plans, as well as Commercial, Market-place and Medicare plans.<sup>18</sup> While these reports are widely available online, unlike state-specific reports they are not provided to consumers at the time of enrollment, nor are they necessarily inclusive of every health plan option within the state. It is not known whether and to what extent consumers may be using these tools to select a health plan.



Medicaid managed care rating systems also vary widely in how they benchmark and report the results to consumers.



Table 1 presents some key information on Medicaid quality rating systems.<sup>19</sup>

**Table 1. Overview of Existing Medicaid Managed Care Quality Rating Systems**

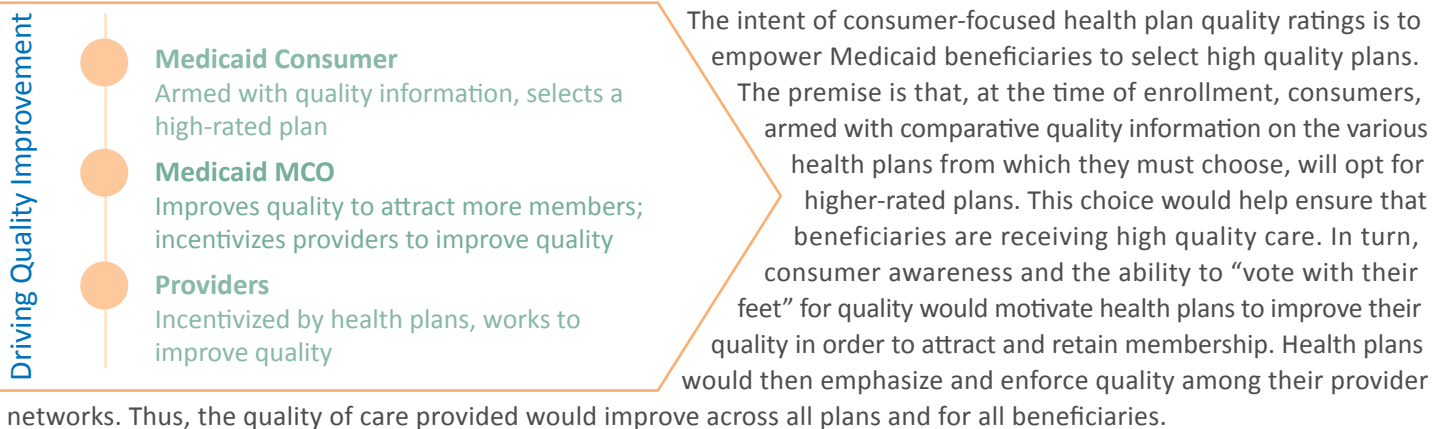
State/ Program	State or Region- Specific	Rating Scale	Individual Measures or Composites	Performance Areas Measured
Kentucky <sup>20</sup>	State	5 Stars	Individual	<p><b>Preventive Care:</b> Child Immunizations, Well-Child Visits in the First 15 Months of Life, Well-Child Visits Ages 3 to 6, Adolescent Immunizations, Adolescent Well-Child, Cervical Cancer Screening, Prenatal Care</p> <p><b>Access to Care:</b> Child Doctor Availability, 21 and Under Dental Visits, Adult Doctor Visits, Adult Doctor Availability</p> <p><b>Getting Help When Needed:</b> Getting Child Care Quickly, Child Customer Service, Parent Overall Satisfaction with Child's Health Plan, Getting Adult Care Quickly, Adult Customer Service, Adult Overall Satisfaction with Health Plan</p>
Maryland <sup>21</sup>	State	3 Stars	Composite	<p><b>Access to Care</b></p> <p><b>Doctor Communication and Service</b></p> <p><b>Keeping Kids Healthy</b></p> <p><b>Care for Kids with Chronic Illness</b></p> <p><b>Taking Care of Women</b></p> <p><b>Care for Adults with Chronic Illness</b></p>
Michigan <sup>22</sup>	State	3 Apples	Composite	<p><b>Doctor Communication and Service</b></p> <p><b>Getting Care</b></p> <p><b>Keeping Kids Healthy</b></p> <p><b>Living with Illness</b></p> <p><b>Taking Care of Women</b></p> <p><b>Accreditation organization<sup>23</sup></b></p>
New York <sup>24</sup>	Region	5 Stars	Individual	<p><b>Preventive and Well-Care for Adults and Children:</b> Child and Adolescent Well-Care, Women's Preventive Care, Maternal Care, Adult Care</p> <p><b>Quality of Care Provided to Members with Illnesses:</b> Care for Respiratory Conditions, Diabetes Care, Cardiovascular Care, Mental Health</p> <p><b>Patient Satisfaction with Access and Service:</b> Satisfaction with Adult's Care, Satisfaction with Children's Care</p> <p><b>Overall Rating</b></p>

State/ Program	State or Region- Specific	Rating Scale	Individual Measures or Composites	Performance Areas Measured
Ohio <sup>25</sup>	State	3 Stars	Composite	<b>Getting Care</b> <b>Doctors' Communication and Service</b> <b>Keeping Kids Healthy</b> <b>Living with Illness</b> <b>Women's Health</b>
Pennsylvania	Region	3 Stars	Individual	<b>Asthma</b> <b>Children's Dental</b> <b>Children's Health</b> <b>High Blood Pressure</b> <b>Diabetes</b> <b>Maternity</b> <b>Women's Health</b> <b>Getting Needed Care</b> <b>Satisfaction with Health Plan</b>
Texas <sup>26</sup>	Region	3 Stars	Individual	<b>Getting Timely Care:</b> Did people get care right away when they needed it? <b>Getting Needed Care:</b> Did people get the care, tests and treatment they needed? <b>Main Doctor:</b> How did people rate their main doctor? <b>Health Plan:</b> How did people rate this health plan? <b>Prenatal Care:</b> Did pregnant mothers get their prenatal checkups? <b>New Mother Care:</b> Did new mothers get their checkups 3 to 8 weeks after giving birth? <b>Cervical Cancer Screening:</b> Did women get screened for cervical cancer? <b>Diabetes:</b> How well does the health plan care for people with diabetes? <b>Performance Rating:</b> How well does this health plan perform?
NCQA Health Plan Report Card	State	4 Stars	Composite	<b>Access and Service</b> <b>Qualified Providers</b> <b>Staying Healthy</b> <b>Getting Better</b> <b>Living with Illness</b>
NCQA Health Insurance Plan Ratings	State	Scale of 1 to 5	Composite	<b>Consumer Satisfaction</b> <b>Prevention</b> <b>Treatment</b>

States incorporate their Medicaid health plan ratings into consumer guides that comply with the language and reading level requirements of materials produced for Medicaid consumers. In an effort to be concise and user-friendly, many state guides do not fully explain how they define below average, above average, and average ratings, which individual measures comprise each composite category, or how individual measures are weighted within the composite. Although this approach yields a more concise tool for consumers to use, it can also result in less transparency of what comprises the overall rating. Consequently this can mask limitations in the individual measures that comprise the composite. Less transparency can also limit the ability of plans to identify specific areas for improvement.

## QUALITY RATING SYSTEMS MAY DRIVE QUALITY IMPROVEMENT

By organizing quality information in a systematic and easily digestible way that allows comparison across health plans, Medicaid managed care quality rating systems have the potential to improve the health care delivered to members.



State Medicaid agencies can use complementary strategies to augment the impact of quality ratings in order to accelerate quality improvement. With the addition of "teeth" to the ratings, health plans and providers may use the ratings to identify quality improvement opportunities and focus improvement efforts through performance improvement projects (PIPs)<sup>27</sup> and other means.

For instance, states may use MCOs' quality ratings to inform development of their quality improvement goals and objectives and direct their oversight of health plans. States can also set minimum quality ratings as a contracting requirement. Another state strategy is to support greater enrollment in higher-rated plans, such as increasing the proportion of auto-assigned members to higher-rated plans. In 2015, eight states employed this strategy, thus increasing enrollment and market share for higher quality plans.<sup>28</sup>

**States may use MCOs' quality ratings to inform development of their quality improvement goals and objectives and direct their oversight of health plans.**

States may provide direct financial incentives to plans to raise performance. States are increasingly moving toward value-based payments for their Medicaid plans, incorporating such P4P strategies as bonuses, higher capitation rates, or releasing a withheld portion of payment to health plans that meet specified quality goals. P4P goals are often based on a select portion of the HEDIS®, CAHPS®, or other quality measures that the health plans are required to report, and typically involve attaining a percentile of a state or national standard (such as the HEDIS® Medicaid 90th percentile). In some states, these value-based payments put Medicaid MCOs at considerable risk; ensuring these payments are received is a significant focus of the health plans. In Texas, for example, \$90 million in Medicaid payments was at risk in state fiscal year 2015.<sup>29</sup>



Likewise, Medicaid MCOs can incentivize providers to improve quality along dimensions of care that relate back to the plans' quality ratings. For instance, plans can implement selective contracting, selective assignment of members to high-performing primary care providers, higher capitation rates, or P4P bonus payments. These payment mechanisms could be implemented directly by health plans in their contracting with providers, or incorporated into the state's quality approach and managed care plan contracts.



Medicaid MCOs can incentivize providers to improve quality along dimensions of care that relate back to the plans' quality ratings.

## THE PROMISE OF QUALITY RATING SYSTEMS

### Content Highlight

Although anecdotal evidence suggests that some consumers look at quality ratings at the time of enrollment, more research is needed to assess whether quality rating systems in Medicaid managed care would truly impact consumer, health plan, and provider behavior.

There is considerable debate surrounding the extent to which Medicaid managed care quality rating systems truly impact consumer, health plan and provider behavior. Anecdotal evidence<sup>30</sup> in some states suggests that some consumers do indeed look at, and question, quality ratings at the time of enrollment. Health plans also pay attention. However, to date, quality rating systems in Medicaid managed care programs lack sufficient empirical study.

#### The Impact on Medicaid Consumers

Despite significant focus on making information available to consumers to empower them to knowledgeably and actively make health care and health plan decisions, relatively few studies assess the impact of using comparative performance data to select health plans. Most of the research that has been done related to selecting health care is

focused on selecting doctors and hospitals—selection decisions that can be very different from choosing a health plan.<sup>31,32</sup>

The small research base related to health plan selection has largely focused on commercial populations, public employees, and Medicare beneficiaries—populations with markedly different demographics than Medicaid beneficiaries.<sup>33,34</sup>

The evidence base among non-Medicaid populations shows mixed results for quality rating systems—studies of publicly reported quality information had no consistent or significant effect on the health plan choices of commercial populations—and varied results among public employees.<sup>35</sup> The Medicare Advantage (MA) Star Ratings, which have garnered some attention lately for their impact on quality among MA plans, also show limited evidence of use among consumers. While at least one study shows that MA members tend to choose higher rated plans, still others indicate that many beneficiaries are not aware of the star ratings, calling into question of the driver of enrollment in high quality plans.<sup>36,37</sup> Further, among studies that have shown higher Medicare star ratings associated with increased enrollment, the association was less strong with younger, black, low-income, and rural enrollees, highlighting how the Medicare findings are likely of limited applicability to Medicaid populations.<sup>38</sup>

The evidence on the impact of public reporting of Medicaid health plan quality information on plan choice suggests that simply providing quality ratings to consumers is not sufficient to ensure their use. Three studies, now over a decade old, assessed the impact of providing consumers with information on Medicaid plans' CAHPS<sup>®</sup> performance ratings.<sup>39,40,41</sup> The results were similar in each state studied (New Jersey, Iowa, and Kansas)—health plan selection did not change as a result of receiving the comparative quality information. However, nearly 15 years later, advances in technology (e.g., smartphones, more sophisticated web applications) may improve access to and usability of plan performance ratings by Medicaid consumers.<sup>42</sup>

In general, a number of factors impact consumers' use of quality ratings in making decisions, including the manner in which ratings are displayed and described and the ability of consumers to digest the information.<sup>43</sup> Primary reasons that available public reports do not influence consumers' plan selection include: 1) consumers do not need or value the information; 2) the information is not easy to understand; 3) consumers have doubts about the trustworthiness and relevance of metrics; and 4) the reports and websites are too complex.<sup>44,45,46</sup>

Consumers also may need more guidance in understanding how the information presented in quality measures or a score card reflects – or does not reflect – the performance of the plan. For example, context that clearly describes why a metric, such as the percentage of women enrolled in the plan who received annual mammograms, is important and relevant at the health plan level could help consumers understand how to use this information in selecting a plan. Similarly, greater explanation on why plans may receive a rating of “NA” (not applicable) could help ensure that consumers do not dismiss those plans, due to lack of a star rating, when comparing available options.

The National Quality Strategy has recognized that, in order to be effective, public reporting “requires the development and implementation of evidence-based practices around the types of measures reported, the level of detail that various key audiences want, and how information should be displayed.”<sup>47</sup> This recognition of the need for understandable information highlights the complex balance between transparency of measures and methodology and “information overload” for consumers.

Even when armed with understandable and actionable quality information, consumers may not prioritize health plan quality relative to other competing factors. Factors such as the size of the provider network, the ability to continue seeing a current provider, the availability of medications on the prescription drug formulary, and name recognition are powerful drivers of health plan selection behavior.<sup>48</sup>

**Even when armed with understandable and actionable quality information, consumers may not prioritize health plan quality relative to other competing factors.**

Finally, many Medicaid beneficiaries forgo the opportunity to make a voluntary plan selection, and instead are auto-assigned to a health plan by the state Medicaid agency. In some states, auto-assignment constitutes the majority of Medicaid health plan enrollments.<sup>49</sup>

Taken together, the myriad factors that impact the ability and willingness of a consumer to use Medicaid health plan quality ratings in their health plan selection pose challenges for producing ratings that drive enrollment.

### The Impact on Health Plans

To date, little research has examined the impact of Medicaid health plan quality ratings on health plan behavior change. However, consistent evidence from the Medicare Advantage (MA) Star Ratings program, though not directly applicable to Medicaid, suggests that MA plans have responded to the sizeable financial and preferential enrollment incentives that are awarded to high-performing plans.<sup>50,51</sup> Significant year-over-year improvement in the number of MA plans that achieve 5-Star ratings demonstrate that these ratings are driving improvements in quality.<sup>52</sup>

Of the states that currently utilize consumer-focused rating systems in their Medicaid programs, none have explicitly linked financial incentives to the rating systems as CMS has with the MA star ratings.<sup>53</sup> Regardless, Medicaid MCOs have strong motivations to improve quality of care. As previously noted, P4P goals are often based on meeting state or national standards for selected HEDIS<sup>®</sup>, CAHPS<sup>®</sup>, or other quality measures;<sup>54</sup> more than a dozen states require NCQA accreditation of MCOs; and PIP projects are required by all state Medicaid managed care programs. Furthermore, as Medicaid managed care procurements increasingly rely on a health plan's performance in all markets in which the plan operates, national plans have an additional imperative to improve quality of care to ensure future contract awards.<sup>55</sup> In addition, states may indirectly link financial incentives to consumer-focused ratings through measure alignment with broader value-based purchasing efforts (e.g., P4P) or preferential auto-enrollment policies for high quality plans.

## Medicaid MCOs have strong motivations to improve quality of care.



More than a dozen states require NCQA accreditation of MCOs



PIP projects are required by all state Medicaid managed care programs



Medicaid managed care procurements increasingly rely on a health plan's performance in all markets in which the plan operates; national plans have an additional imperative to improve quality of care to ensure future contract awards.



P4P goals are often based on meeting state or national standards for selected HEDIS®, CAHPS®, or other quality measures



States may indirectly link financial incentives to consumer-focused ratings through measure alignment with broader value-based purchasing efforts (e.g., P4P) or preferential auto-enrollment policies for high quality plans.

In contrast, when these requirements and incentives do not align,<sup>56</sup> the initiatives compete for quality improvement resources within the health plan. The unintended consequence may be that the impact of each incentive is diluted.<sup>57</sup> While some health plans report that they work to improve any measure that is consumer-facing, other health plans state that, if the measures are not aligned, measures with significant financial incentives (P4P) are prioritized and garner the resources, focus and attention.<sup>58</sup> Therefore, the alignment or misalignment of consumer-focused rating systems with other quality improvement efforts is a critical factor in considering whether these rating systems lead to health plan behavior change.

Lastly, transparency also influences the extent to which quality ratings drive health plan behavior. Health plans are better able to track and target improvement interventions if the ratings and methodologies for calculating them are evident. For example, Michigan defines “Keeping Kids Healthy” as whether “children in the plan get regular checkups and important shots that help protect them against serious illness.” It is not clear, though, whether standard HEDIS® measures or state-specific adaptations are included; whether these measures are reported by the health plans or calculated by the state; and how these measures are rolled up to the composite rating.

### The Impact on Providers

As with consumers and health plans, few studies have examined the impact of quality rating systems on provider behavior. To date, there is little evidence that providers are responding to Medicaid managed care quality rating systems by improving quality. However, this may be changing with the shift to more value-based payment arrangements in Medicaid.

Anecdotal evidence<sup>59</sup> suggests that health plans are seeking to develop innovative partnerships with providers to improve performance relative to consumer-focused rating systems. As quality ratings evolve, these collaborations may advance. In terms of value-based purchasing as a whole, regardless of whether linked to consumer-focused rating systems, efforts

to involve and incentivize providers are underway, evolving, and garnering considerable interest among state Medicaid programs.<sup>60</sup> The impacts of value-based arrangements to date show mixed results across populations,<sup>61</sup> and for Medicaid health plans it can be even harder to implement these arrangements.<sup>62</sup> Medicaid populations have, on average, more complex health conditions, higher medical costs, and economic and social challenges that make cost containment efforts more challenging because more



Anecdotal evidence suggests that health plans are seeking to develop innovative partnerships with providers to improve performance relative to consumer-focused rating systems.

coordination between multiple health care providers and providers of other types of services is required. In addition, limits on cost sharing for enrollees limits the ability of Medicaid plans to influence enrollee provider choice, and lower payment rates in Medicaid compared to other payers creates a greater challenge in attracting and engaging providers in these pay-based

reform efforts. Despite these limitations though, value-based payments in Medicaid programs are continuing to flourish, and pilots and demonstration programs are showing promising results—an early indicator that these programs could continue to grow and gain larger scale traction and positive impacts on provider behavior.<sup>63,64</sup>

## LOOKING FORWARD: THE IMPACT OF QUALITY RATINGS IN THE FUTURE

### Content Highlight

As Medicaid managed care quality rating systems grow, it is imperative to assess on an ongoing basis whether and to what extent these systems are able to effectively drive changes in consumer, health plan and provider behavior.

Significant efforts are underway to encourage consumers to compare health plan quality. National efforts support health plan ratings and consumer engagement across payers as key building blocks in achieving the national quality goals. In Medicaid, the new managed care regulations bolster these efforts by ensuring all states will implement a quality rating system over the next three years. A handful of states have been out in front of these rules and have already established, or are establishing, their own Medicaid managed care quality rating system. With strong federal commitment to a Medicaid managed care quality rating system and consumer engagement in health care, rating systems are likely to proliferate.

As Medicaid managed care quality rating systems grow, it is imperative to assess on an ongoing basis whether and to what extent these systems are able to effectively drive changes in consumer, health plan and provider behavior. Mixed, but limited, evidence of past efforts demonstrates both potential and the opportunity to improve, and the need to take a broader view. The continued evolution and refinement of Medicaid quality rating systems call for robust empirical studies of not only the ratings, but the consumer education and engagement efforts, to promote greater understanding of what's effective, or not, in driving behavior change among consumers, health plans and providers. Further, additional work should focus on ensuring that consumer-facing quality ratings are comprehensible, relevant, and align with consumers' other priorities and considerations related to health plan selection.

As CMS develops the Medicaid QRS, the agency should recognize and build on the many successful quality measurement programs that states already have in place and take a consultative and collaborative approach. Health plans, in particular, can serve as a valuable partner, given their position to align the goals of state quality rating systems with incentives in provider contracts as well as with member incentive programs that encourage healthy behaviors and wellness (e.g., obtaining preventive care services, health screenings, etc.).

At their core, Medicaid quality rating systems should enhance consumers' ability to choose their health plan, by furnishing beneficiaries with data on health plan quality. With ongoing stakeholder collaboration and refinements, Medicaid managed care quality rating systems can fulfill this promise as effective tools to engage consumers in their health plan selection and drive health plan and provider behavior change, ultimately resulting in higher value health care.

---

*This paper is the third of three issue briefs focused on quality measurement and reporting in Medicaid; the others are available at <http://anthempublicpolicyinstitute.com>. The Anthem Public Policy Institute gratefully acknowledges the support of Health Management Associates in the research and writing of this paper.*

## END NOTES

- <sup>1</sup> U.S. Department of Health & Human Services. (2016, April 25). Managed Care. Retrieved April 28, 2016, from <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html>
  - <sup>2</sup> Committee on Quality of Health Care in America, Institute of Medicine. (2001). Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, D.C.: The National Academy Press.
  - <sup>3</sup> Murthy, L., Shepperd, S., Clarke, M. J., Garner, S. E., Lavis, J. N., Perrier, L.,...Straus, S. E. (2012). Interventions to improve the use of systematic reviews in decision-making by health system managers, policy makers and clinicians. Cochrane Database of Systematic Reviews. doi:10.1002/14651858.cd009401.pub2
  - <sup>4</sup> Blumenthal, D., Malphrus, E., & McGinnis, J. M. (2015). Vital Signs: Core Metrics for Health and Health Care Progress. Washington, D.C.: The National Academies Press.
  - <sup>5</sup> U.S. Department of Health & Human Services. (2016, April 25). Managed Care. Retrieved April 28, 2016, from <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html>
  - <sup>6</sup> The Qualified Health Plan (QHP) Quality Rating System (QRS) is a reporting requirement of all Qualified Health Plan (QHP) issuers operating in the Health Insurance Marketplaces (or Exchanges). The QHP QRS is in beta testing in 2015 and 2016, for eventual release to consumers during the 2016 open enrollment period for the 2017 coverage year. The QRS measure set consists of 43 measures, 12 of which are survey measures that will be collected as part of the QHP Enrollee Survey (largely based on CAHPS<sup>®</sup>). In 2015, 29 measures were beta-tested and the remaining measures require 2 years of data and will be released in 2016. QHP scores will be calculated using a standardized methodology that includes rules for combining and scoring QRS measures through a hierarchical structure, resulting in one global score. Based on the scores, CMS will assign each QHP a star rating using a 1 to 5 scale. Ratings were not required to be publicly available in 2015, but will be going forward.
  - <sup>7</sup> Assistant Secretary for Public Affairs (ASPA). (2015, August 13). Key Features of the Affordable Care Act By Year. Retrieved May 2, 2016, from <http://www.hhs.gov/healthcare/facts-and-features/key-features-of-aca-by-year/index.html>
  - <sup>8</sup> Mittler, J. N., Martzolf, G. R., Telenko, S. J., & Scanlon, D. P. (2013). Making Sense of “Consumer Engagement” Initiatives to Improve Health and Health Care: A Conceptual Framework to Guide Policy and Practice. The Milbank Quarterly, 91(1), 37-77. doi:10.1111/milq.12002
  - <sup>9</sup> U.S. Department of Health & Human Services. (2011, March). Report to Congress: National Strategy for Quality Improvement in Health Care (Rep.). Retrieved May 2, 2016, from U.S. Department of Health & Human Services website: <http://www.ahrq.gov/workingforquality/nqs/nqs2011annlrpt.pdf>
  - <sup>10</sup> National Prevention Council. (2011, June). National Prevention Strategy: America’s Plan for a Better Health and Wellness (Rep.). Retrieved May 2, 2016, from U.S. Department of Health and Human Services, Office of the Surgeon General website: <http://www.surgeongeneral.gov/priorities/prevention/strategy-report.pdf>
  - <sup>11</sup> HEDIS<sup>®</sup> is a registered trademark of the National Committee for Quality Assurance.
  - <sup>12</sup> Smith, V. K., Gifford, K., Ellis, E., Rudowitz, R., Snyder, L., & Hinton, E. (2015, October). Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016 (Rep.). Retrieved May 2, 2016, from The Henry J. Kaiser Family Foundation website: <http://files.kff.org/attachment/report-medicare-reforms-to-expand-coverage-control-costs-and-improve-care-results-from-a-50-state-medicare-budget-survey-for-state-fiscal-years-2015-and-2016>
  - <sup>13</sup> National Committee for Quality Assurance. (n.d.). About NCQA. Retrieved May 2, 2016, from <http://www.ncqa.org/AboutNCQA.aspx>
  - <sup>14</sup> National Committee for Quality Assurance. (n.d.). Health Plan Accreditation. Retrieved May 2, 2016, from <http://www.ncqa.org/programs/accreditation/health-plan-hp>
  - <sup>15</sup> Medicaid plans other states often obtain NCQA accreditation voluntarily.
  - <sup>16</sup> The state of quality measurement in Medicaid managed care is discussed in detail in a companion paper: Anthem Public Policy Institute (n.d.). The “Nuts and Bolts” Behind Quality Measurement in Medicaid Managed Care.
  - <sup>17</sup> At the time of this report, the authors are aware of quality rating systems in seven states: Kentucky, Maryland, Michigan, New York, Ohio, Pennsylvania, and Texas, as well as two states that are starting to develop quality rating systems – Florida and Illinois. If other states currently have quality rating systems, the authors were not aware and therefore the information in this report may not apply. South Carolina includes a Medicaid Health Plans Report Card in its Report on Medicaid Health Care Performance, but is not included here, as it is a comprehensive suite of measures required for reporting rather than a report developed for and provided to consumers.
  - <sup>18</sup> National Committee for Quality Assurance. (n.d.). Health Plans. Retrieved May 2, 2016, from <http://www.ncqa.org/ReportCards/HealthPlans.aspx>
- The Health Plan Report Card tool creates report cards for NCQA-Accredited plans, whereas the Health Insurance Plan Ratings is a larger data set, including both Accredited and non-Accredited plans.



19. This list may not be exhaustive. In addition, Florida and Illinois are starting to develop rating systems.
20. Member's Guide to Choosing a Medicaid Health Plan [Brochure]. (2015). Retrieved May 2, 2016, from <http://chfs.ky.gov/NR/rdonlyres/0197AE79-ED57-4D5E-AE9C-85E7713085A1/0/KY2015REPORTCARD81015.pdf>
21. HealthChoice: Maryland's Medicaid Health Plan Program. (2015, March). A Performance Report Card for Consumers 2015 [Digital image]. Retrieved May 3, 2016, from [https://www.marylandhealthconnection.gov/assets/MDEQRO\\_Report\\_Card2015.pdf](https://www.marylandhealthconnection.gov/assets/MDEQRO_Report_Card2015.pdf)
22. Michigan Department of Health & Human Services. (2016). A Guide to Michigan Medicaid Health Plans [Brochure]. Retrieved May 2, 2016, from [http://www.michigan.gov/documents/QualityCheckupJan03\\_59423\\_7.pdf?\\_sm\\_au\\_=iVVTNssWMJHstRnD](http://www.michigan.gov/documents/QualityCheckupJan03_59423_7.pdf?_sm_au_=iVVTNssWMJHstRnD)
23. Michigan requires either NCQA or URAC Accreditation of its health plans.
24. New York State Department of Health. (2015, November). 2015 Managed Care Regional Consumer Guides. Retrieved May 2, 2016, from [http://www.health.ny.gov/health\\_care/managed\\_care/consumer\\_guides/?\\_sm\\_au\\_=iVVTNssWMJHstRnD](http://www.health.ny.gov/health_care/managed_care/consumer_guides/?_sm_au_=iVVTNssWMJHstRnD)
25. Ohio Department of Medicaid. (2015, June). 2015. Managed Care Plans Report Card [PDF]. Ohio Department of Medicaid.
26. Texas Health and Human Services Commission. (n.d.). STAR Health Plan Report Cards. Retrieved May 2, 2016 <http://www.hhsc.state.tx.us/QuickAnswers/report-cards/star.shtml>
27. PIPs are federally required efforts to improve the quality of care through health plan-level projects. Some states require their health plans to participate in state-level collaboratives for a chosen topic, while in other states Medicaid plans select their own topics for improvement. PIPs are validated by the state's EQRO to ensure that they are designed, conducted, and reported in a methodologically sound manner.
28. Smith, V. K., Gifford, K., Ellis, E., Rudowitz, R., Snyder, L., & Hinton, E. (2015, October). Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016 (Rep.). Retrieved May 2, 2016, from The Henry J. Kaiser Family Foundation website: <http://files.kff.org/attachment/report-medicare-reforms-to-expand-coverage-control-costs-and-improve-care-results-from-a-50-state-medicare-budget-survey-for-state-fiscal-years-2015-and-2016>
29. Health Management Associates Interview with Experts in the Quality Field including Representatives from Health Plans and Health Measurement Organizations [Telephone interview]. (2015, December to 2016, February).
30. Health Management Associates Interview with Enrollment Representatives in Several States [Telephone interview]. (2016, February).
31. Kolstad, J. T., & Chernew, M. E. (2009, February). Quality and Consumer Decision Making in the Market for Health Insurance and Health Care Services. *Medical Care Research and Review*, 66(1), suppl, 28S-52S. doi:10.1177/1077558708325887
32. Generally, the literature on consumer use of provider quality report cards shows that consumers have difficulty understanding and remembering the information. Moreover, this literature base likely has little relevance to health plan quality ratings, as these choices are very different—health plans are typically chosen in a time of health, whereas providers are typically chosen in a short timeframe following the diagnosis of a condition or ailment.
33. Totten, A. M., Wagner, J., Tiwari, A., O'Haire, C., Griffin, J., & Walker, M. (2012, July). 5. Public Reporting as a Quality Improvement Strategy, Closing the Quality Gap: Revisiting the State of the Science (Rep.). Retrieved May 2, 2016, from Agency for Healthcare Research & Quality website: [https://www.effectivehealthcare.ahrq.gov/ehc/products/343/1199/EvidReport208\\_CQGPUBLICREPORTING\\_FinalReport\\_20120724.pdf](https://www.effectivehealthcare.ahrq.gov/ehc/products/343/1199/EvidReport208_CQGPUBLICREPORTING_FinalReport_20120724.pdf)
34. Kolstad, J. T., & Chernew, M. E. (2009, February). Quality and Consumer Decision Making in the Market for Health Insurance and Health Care Services. *Medical Care Research and Review*, 66(1), suppl, 28S-52S. doi:10.1177/1077558708325887
35. Totten, A. M., Wagner, J., Tiwari, A., O'Haire, C., Griffin, J., & Walker, M. (2012, July). 5. Public Reporting as a Quality Improvement Strategy, Closing the Quality Gap: Revisiting the State of the Science (Rep.). Retrieved May 2, 2016, from Agency for Healthcare Research & Quality website: [https://www.effectivehealthcare.ahrq.gov/ehc/products/343/1199/EvidReport208\\_CQGPUBLICREPORTING\\_FinalReport\\_20120724.pdf](https://www.effectivehealthcare.ahrq.gov/ehc/products/343/1199/EvidReport208_CQGPUBLICREPORTING_FinalReport_20120724.pdf)
36. Harris Interactive. (2011, October). Medicare Star Quality Rating System Study: Key Findings (Rep.). Retrieved May 2, 2016, from Harris Interactive Inc. website: <https://kaiserhealthnews.files.wordpress.com/2012/05/101011medicarestarqualityratingssystemstudykeyfindings.pdf>
37. Kolstad, J. T., & Chernew, M. E. (2009, February). Quality and Consumer Decision Making in the Market for Health Insurance and Health Care Services. *Medical Care Research and Review*, 66(1), suppl, 28S-52S. doi:10.1177/1077558708325887
38. Reid, R. O., Deb, P., Howell, B. L., & Shrank, W. H. (2013). Association Between Medicare Advantage Plan Star Ratings and Enrollment. *The Journal of the American Medical Association*, 309(3), 267-274. doi:10.1001/jama.2012.173925
39. Farley, D. O., Short, P. F., Elliott, M. N., Kanouse, D. E., Brown, J. A., & Hays, R. D. (2002). Effects of CAHPS Health Plan Performance Information on Plan Choices by New Jersey Medicaid Beneficiaries. *Health Services Research*, 37(4), 985-1007. doi:10.1034/j.1600-0560.2002.62.x
40. Farley, D. O., Elliott, M. N., Short, P. F., Damiano, P., Kanouse, D. E., & Hays, R. D. (2002). Effect of CAHPS Performance Information on Health Plan Choices by Iowa Medicaid Beneficiaries. *Medical Care Research and Review*, 59(3), 319-336. doi:10.1177/107755870205900305

41. Fox, M. H., Moore, J., Zimmerman, M., Hill, S., & Foster, C. H. (2001). The Effectiveness of CAHPS™ among Women Enrolling in Medicaid Managed Care. *Journal of Ambulatory Care Management*, 24(4), 76-91. doi:10.1097/00004479-200110000-00006
  42. Findlay, S. D. (2016). Consumers' Interest In Provider Ratings Grows, And Improved Report Cards And Other Steps Could Accelerate Their Use. *Health Affairs*, 35(4), 688-696. doi:10.1377/hlthaff.2015.1654
  43. Damberg, C. L., & Mcnamara, P. (2014). Postscript: Research Agenda to Guide the Next Generation of Public Reports for Consumers. *Medical Care Research and Review*, 71(5), suppl, 97S-107S. doi:10.1177/1077558714535982
  44. Totten, A. M., Wagner, J., Tiwari, A., O'Haire, C., Griffin, J., & Walker, M. (2012, July). 5. Public Reporting as a Quality Improvement Strategy, Closing the Quality Gap: Revisiting the State of the Science (Rep.). Retrieved May 2, 2016, from Agency for Healthcare Research & Quality website: [https://www.effectivehealthcare.ahrq.gov/ehc/products/343/1199/EvidReport208\\_CQGPublicReporting\\_FinalReport\\_20120724.pdf](https://www.effectivehealthcare.ahrq.gov/ehc/products/343/1199/EvidReport208_CQGPublicReporting_FinalReport_20120724.pdf)
  45. Schlesinger, M., Grob, R., Shaller, D., Martino, S. C., Parker, A. M., Finucane, M. L., . . . Rybowski, L. (2015). Taking Patients' Narratives about Clinicians from Anecdote to Science. *New England Journal of Medicine*, 373(7), 675-679. doi:10.1056/nejmsb1502361
  46. Faber, M., Bosch, M., Wollersheim, H., Leatherman, S., & Grol, R. (2009). Public Reporting in Health Care: How Do Consumers Use Quality-of-Care Information? *Medical Care*, 47(1), 1-8. doi:10.1097/mlr.0b013e3181808bb5
  47. U.S. Department of Health & Human Services (HHS) Public Reporting of Quality and efficiency Measures Workgroup. (2013, December). Prioritizing the Public HHS Public Reporting: Using and Improving Information on Quality, Cost, and Coverage to Support Health Care Improvement [PDF]. Retrieved May 2, 2016, from <http://www.ahrq.gov/workingforquality/reports/hhsreporting.pdf>
  48. Health Management Associates Interview with Experts in the Quality Field including Representatives from Health Plans and Health Measurement Organizations [Telephone interview]. (2015, December to 2016, February).
  49. Smith, V. K., Gifford, K., Ellis, E., Rudowitz, R., Snyder, L., & Hinton, E. (2015, October). Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016 (Rep.). Retrieved May 2, 2016, from The Henry J. Kaiser Family Foundation website: <http://files.kff.org/attachment/report-medicare-reforms-to-expand-coverage-control-costs-and-improve-care-results-from-a-50-state-medicare-budget-survey-for-state-fiscal-years-2015-and-2016>
- The proportion of beneficiaries who are auto-enrolled varies widely across states. Of the 39 states with comprehensive risk-based MCOs, six states auto-enrolled over 75 percent of new MCO enrollees.
50. Weaver, C. (2011, October 12). Chasing The Stars, Insurers Improve Quality—And Revenue. *Kaiser Health News*. Retrieved May 2, 2016, from <http://khn.org/news/insurers-improve-quality-revenue/>
  51. Reid, R. O., Deb, P., Howell, B. L., & Shrank, W. H. (2013). Association Between Medicare Advantage Plan Star Ratings and Enrollment. *The Journal of the American Medical Association*, 309(3), 267-274. doi:10.1001/jama.2012.173925
  52. Cheney, C. (2014, October 14). 16 Medicare Advantage Plans Earn 5-Star Ratings. *HealthLeaders Media*. Retrieved May 2, 2016, from <http://www.healthleadersmedia.com/health-plans/16-medicare-advantage-plans-earn-5-star-ratings#>
  53. Health Management Associates Interview with Experts in the Quality Field including Representatives from Health Plans and Health Measurement Organizations [Telephone interview]. (2015, December to 2016, February).
  54. Smith, V. K., Gifford, K., Ellis, E., Rudowitz, R., Snyder, L., & Hinton, E. (2015, October). Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016 (Rep.). Retrieved May 2, 2016, from The Henry J. Kaiser Family Foundation website: <http://files.kff.org/attachment/report-medicare-reforms-to-expand-coverage-control-costs-and-improve-care-results-from-a-50-state-medicare-budget-survey-for-state-fiscal-years-2015-and-2016>
  55. Medicaid managed care procurements request quality information, particularly HEDIS® performance, from a health plan's affiliated plans. While state Requests for Proposals (RFPs) traditionally requested that health plans provide select information, it is now increasingly common that RFPs request quality information from all affiliated plans, limiting a health plan's ability to "cherry pick" their stronger performers.
  56. Health Management Associates Telephone Interview with Anthem, Inc. Subject Matter Experts [Telephone interview]. (2016, January 19).
  57. Health Management Associates Telephone Interview with Anthem, Inc. Subject Matter Experts [Telephone interview]. (2016, January 19).
  58. Health Management Associates Telephone Interviews with Anthem Affiliated Health Plans' Subject Matter Experts [Telephone interviews]. (2016, January 6 and 14).
  59. Health Management Associates Telephone Interview with Anthem, Inc. Subject Matter Experts [Telephone interview]. (2016, January 19).
  60. As evidenced by their prominence in state RFPs for managed care procurements.
  61. Goldberg, D. (2015, May 4). Broad agreement, and big questions, on value-based payments. *Politico*. Retrieved May 2, 2016, from <http://www.politico.com/states/new-york/albany/story/2015/05/broad-agreement-and-big-questions-on-value-based-payments-000000>

<sup>62</sup>. Dybdal, K., Blewett, L., Sonier, J., & Spencer, D. (2014, February). Paying for Value in Medicaid: A Synthesis of Advanced Payment Models in Four States (Rep.). Retrieved May 2, 2016, from Minnesota Department of Human Services website: [http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16\\_182844](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_182844)

<sup>63</sup>. Ellertson, N. (2015). A Healthy Partnership: Medicaid Managed Care Organizations and Federally Qualified Health Centers [White paper]. Retrieved 2 May 2016, from Optum, Inc.: [https://www.optum.com/content/dam/optum/resources/whitePapers/An\\_Ounce\\_of\\_Prevention\\_May\\_be\\_Worth\\_More\\_Than\\_a\\_Pound\\_of\\_Cure.pdf](https://www.optum.com/content/dam/optum/resources/whitePapers/An_Ounce_of_Prevention_May_be_Worth_More_Than_a_Pound_of_Cure.pdf)

<sup>64</sup>. McGinnis, T. (2015, March 11). A Unicorn Realized? Promising Medicaid ACO Programs Really Exist [Web log post]. Retrieved May 2, 2016, from <http://www.commonwealthfund.org/publications/blog/2015/mar/unicorn-realized-medicaid-acos>



**About the Anthem Public Policy Institute**

The Anthem Public Policy Institute was established to share data and insights to inform public policy and shape the health care programs of the future. The Public Policy Institute strives to be an objective and credible contributor to health care innovation and transformation through publication of policy-relevant data analysis, timely research, and insights from Anthem's innovative programs.

**About Anthem, Inc.**

Anthem is working to transform health care with trusted and caring solutions. Our health plan companies deliver quality products and services that give their members access to the care they need. With over 73 million people served by its affiliated companies, including more than 39 million enrolled in its family of health plans, Anthem is one of the nation's leading health benefits companies. For more information about Anthem's family of companies, please visit [www.antheminc.com/companies](http://www.antheminc.com/companies).