

New York appreciates the opportunity to respond to the Request for Information Regarding Health Care Quality for Exchanges [CMS – 9962 – NC] and offers the following information and recommendations:

Question 1

What quality improvement strategies do health insurance issuers currently use to drive health care quality improvement in the following categories?

1. **Improving health outcomes**

As the State Medicaid agency, the New York State Department of Health (NYS DOH) publicly reports results to inform consumers, target quality improvement activities for plans with poor performance and provide financial incentives for Medicaid. We know plans have used various strategies of provider and member reminders and incentives, care management, and outreach to improve and measure performance and thereby health outcomes.

2. **Preventing hospital readmissions**

NYS DOH has led a Readmission Performance Improvement Project collaborative with Medicaid plans. Ten health plans participated in the project; all of the plans engaged at least one hospital and several engaged primary care providers and/or home health agencies, such as the Visiting Nurse Service. Most projects involved a transition program based on the Coleman model or Care Transitions adapted for the Medicaid population, and included health coaching and/or case management. The most common targeted populations included members with chronic conditions (e.g. asthma, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes, hypertension), but one plan focused on obstetric patients and another focused on members with behavioral health comorbidity. We also use potentially preventable readmissions in our rate setting methodology with Medicaid plans.

3. **Improving patient safety and reducing medical errors**

NYS Medicaid has implemented a policy to not reimburse hospitals for 'Never Events'.

4. **Implementing wellness and health promotion activities**

Similar to how we use health outcomes information, NYS DOH uses preventive care data for reports, improvement activities and incentives in the same fashion. We work collaboratively with the Public Health and Local Health programming to provide data and information to evaluate initiatives and identify areas of need.

5. **Reducing health disparities**

NYS DOH uses data to evaluate differences in care between populations using variables such as poverty, age, gender, ethnicity, race, disability status and geographic location for Medicaid plans. We publish this information on our website and share it with plans so they see where they need to target their efforts. In addition, the Department has engaged providers and plans in improvement activities targeted to eliminating racial and ethnic disparities for chronic diseases such as asthma.

Question 2

What challenges exist with quality improvement strategy metrics and tracking quality improvement over time (for example, measure selection criteria, data collection and reporting requirements)? What strategies (including those related to health information technology) could mitigate these challenges?

- **Challenges:**
 - Measure specification changes which don't allow for trending;
 - Health plan mergers which create gaps in data collection; and
 - Data collection burden which can diffuse focus on improvement are all challenges.

- **Strategies:**
 - Prioritize quality metrics being used in HEDIS, with alignment with other requirements for any measures beyond HEDIS (i.e. CHIPRA, CMS, NQF);
 - Measures outside of HEDIS require programming not included in certified software and are not in audit processes which may affect consistency in collection and comparability; and
 - Consider measures that can be collected administratively to alleviate burden.

Question 3

Describe current public reporting or transparency efforts that states and private entities use to display health care quality information.

- NYS DOH publishes health plan data in several publications including presenting plan results for all measures with comparison to statewide averages, consumer friendly guides for selecting health plans, and related information such as a demographic report which presents data using member characteristics such as race, age and gender (disparities).

Question 4

How do health insurance issuers currently monitor the performance of hospitals and other providers with which they have relationships? Do health insurance issuers monitor patient safety statistics, such as hospital acquired conditions and mortality outcomes, and if so, how? Do health insurance issuers monitor care coordination activities, such as hospital discharge planning activities, and outcomes of care coordination activities, and if so, how?

- As a State, we are aware that plans use mechanisms to monitor provider quality performance with data as well as in contract negotiations. Specifics would be better described from plan perspective.
- NYS Medicaid selectively contracts with only high volume providers for specific surgeries such as breast cancer and bariatric surgery in order to reduce complications and improve outcomes.

Question 5

What opportunities exist to further the goals of the National Quality Strategy through quality reporting requirements in the Exchange marketplace?

- Existing quality reporting requirements will be extended to QHPs, with the Exchange marketplace allowing for the information to be readily available to consumers and small businesses at the time that they are selecting a health plan.
- The goals of the National Quality Strategy would be advanced by aligning measures with those currently collected to streamline reporting and improve consistency as it builds on the infrastructure of programming and auditing in place for many insurers. The collection of quality data would be efficient and not add costs for evaluation as well as will allow identification of

best practices to share as the results would be comparable across QHP and between QHPs and other insurance offerings.

Question 6

What quality measures or measure sets currently required or recognized by states, accrediting entities, or CMS are most relevant to the Exchange marketplace?

- We believe that HEDIS and CAHPS are most relevant to the Exchange marketplace.

The NYS DOH collects, analyzes and publicly reports health plan performance data annually. The data generated from this reporting system, known as the Quality Assurance Reporting Requirements (QARR), are used for a number of different purposes including: providing financial rewards for high quality plans, determining auto-assignment preference, considering health plan expansion requests, measuring continuous quality improvement, and for informing legislators, policy makers and consumers. The QARR data is collected for a variety of plan products including commercial, Medicaid, Child Health Plus and preferred provider organization (PPO).

There are two primary components to the QARR dataset: the access, quality and utilization measures, largely adopted from HEDIS and CAHPS. While QARR data is collected annually, the NCQA does rotate some of their measures in order to allow for improvement cycles to run their course and to reduce the reporting burden on plans. CAHPS data is generally collected annually for commercial insurers and on a biennial basis for Medicaid plans, however under the Affordable Care Act (ACA) CAHPS for Medicaid plans will become an annual endeavor beginning in 2014.

A small number of New York State-specific measures are added to both the quality and satisfaction measures to address areas of particular concern to the state (e.g. quality of adolescent preventive care).

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

Question 7

Are there any gaps in current clinical measure sets that may create challenges for capturing experience in the Exchange?

- We do not believe that there are currently gaps in clinical measures that would create challenges in capturing experience in the Exchange.

Question 8

What are some issues to consider in establishing requirements for an issuer's quality improvement strategy? How might an Exchange evaluate the effectiveness of quality improvement strategies across plans and issuers? What is the value in narrative reports to assess quality improvement strategies?

- We believe there is a need to provide a standard framework for minimum quality improvement strategies. Quality Improvement strategies will vary greatly depending on the catchment area and on the resources available. Sometimes quality improvement can be hampered by the type of insurance. For example, a PPO may consist of several different entities all responsible for different facets of care; the challenge being how to align and share information. Comparison between plans would allow identification of best practices which could then be shared with Exchange plans.

Question 9

What methods should be used to capture and display quality improvement activities? Which publicly and privately funded activities to promote data collection and transparency could be leveraged (for example, Meaningful Use Incentive Program) to inform these methods?

- We believe that Dashboards, Decision Trees, and Flowcharts are effective methods to capture and display quality improvement activities.

Question 10

What are the priority areas for the quality rating in the Exchange marketplace (for example, delivery of specific preventive services, health plan performance and customer service)? Should these be similar to or different from the Medicare Advantage five-star quality rating system (for example, staying healthy: screenings, tests and vaccines; managing chronic (long-term) conditions; ratings of health plan responsiveness and care; health plan members' complaints and appeals; and health plan telephone customer service)?

- We suggest the following as priority areas for quality rating: consumer satisfaction, prenatal care, care for children, adults and persons with chronic health conditions.
- Our research with consumers indicates that rating systems using a few categories of care, with determination of results using comparative thresholds, and which are then aggregated to one overall score, similar to the Medicare Advantage five-star rating, is received well and desirable. NYS DOH does not currently weight measures in the rating system and uses comparative peer norms rather than cut thresholds.

Question 11

What are effective ways to display quality ratings that would be meaningful for Exchange consumers and small employers, especially drawing on lessons learned from public reporting and transparency efforts that states and private entities use to display health care quality information?

- We believe it would be effective to create a summarized score of quality ratings, and to also allow consumers to drill-down to additional levels of details if desired.

Question 12

What types of methodological challenges may exist with public reporting of quality data in an Exchange?
What suggested strategies would facilitate addressing these issues?

- We believe that there could be methodological challenges in using different specifications for collecting data; it may create difficulties in capturing comparable information across different models of care. This challenge could be mitigated by using standardized measurement sets. The degree to which data from the tiers of the Exchange can be aggregated will determine the layers of reporting which may be necessary.

Question 13

Describe any strategies that states are considering to align quality reporting requirements inside and outside the Exchange marketplace, such as creating a quality rating for commercial plans offered in the non- Exchange individual market.

- Using measures that are comparable across products will allow us to monitor how the quality of care differs for those members in commercial plans in the non-exchange market. Not requiring NCQA or URAC accreditation, but requiring the use of HEDIS measures and building off already existing reporting and auditing requirements will minimize plan burden and maximize data completeness.

Question 14

Are there methods or strategies that should be used to track the quality, impact and performance of services for those with accessibility and communication barriers, such as persons with disabilities or limited English proficiency?

- We recommend requiring insurers to collect data at the time of enrollment on: race/ethnicity, language, gender, age, disability status. As additional data collection systems are developed, we would recommend adding additional demographic characteristics such as sexual orientation and other disparities categories as they become defined by CMS. For the purposes of comparability, New York further recommends that data collection standards be implemented inside and outside of the Exchange.

Question 15

What factors should HHS consider in designing an approach to calculate health plan value that would be meaningful to consumers? What are potential benefits and limitations of these factors? How should Exchanges align their programs with value-based purchasing and other new payment models (for example, Accountable Care Organizations) being implemented by payers?

- HHS should attempt to balance cost, accessibility, quality and satisfaction. The benefit of this combined approach is the ability to provide stakeholders with a comprehensive look across insurers. The limitation of this approach is an insurer who performs well in one category may eliminate or decrease a deficiency in another area that may be of equal or more importance to consumer. In addition, HHS should align the quality measurement goals of the exchange with Medicaid and commercial managed care. Creating yet another measurement set is confusing and creates work for plans and states.