New York Health Benefit Exchange

Blueprint Summary for
Section 4.0 Plan Management
Updated February 15, 2013

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4.4	Ensure Ongoing QHP Compliance
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Introduction

The New York Health Benefit Exchange (NYHBE) issued an invitation for insurers to participate in the New York Health Benefit Exchange on January 31, 2013. The complete invitation can be accessed here: http://www.healthbenefitexchange.ny.gov/invitation

Interested parties will submit their non-binding Letter of Interest by February 15, 2013. Applicant proposals and supporting documents are due to the Exchange on April 5, 2013. The Exchange anticipates issuing certification by July 15, 2013.

4.4 Ensure Ongoing QHP Compliance

New York has had extensive experience with joint agency regulation of health plans through the Department of Financial Services (formerly the New York Department of Insurance) and the Department of Health. The NYHBE will leverage this experience by working collaboratively with one another to ensure ongoing compliance.

Currently, health plans are audited in various ways by the Department of Financial Services and the Department of Health. The Exchange will evaluate these audits in collaboration with the agencies to determine whether and/or how the audits need to be modified to accommodate Exchange requirements and minimize any duplicative efforts. A comprehensive audit strategy will be established by December 31, 2013. Below is a description of current oversight by the agencies:

- The Department of Health audits managed care plans, including HMOs, Medicaid Managed Care plans, and Child Health plus plans. These audits generally occur every two years and review regulations, including enrollee appeals and complaints, quality improvement related activities, requirements related to members infected with HIV, organizational structures, and provider agreements.

- The Department of Health also audits Child Health Plus enrollment in managed care plans to ensure enforcement of the eligibility regulations. Given that all Child Health Plus enrollment will occur through the Exchange, it is likely that this audit will no longer need to occur for plan years beginning 2014.

- The Department of Health collects quality and consumer satisfaction data from all health plans through the reporting system known as Quality Assurance Reporting Requirements (QARR). This reporting system is comprised of generally two components: (1) access, quality and utilization measures that are largely adopted from the NCQA Healthcare Effectiveness Data and Information Set (HEDIS); and (2) the consumer experience of care survey questions from the Consumer Assessment of Health Care Providers and Systems (CAHPS) survey. There are approximately 60 HEDIS measures and 20 CAHPS measures. There is also a small number of New York State specific measures that are of particular concern to the state (e.g., quality of adolescent preventive care). The collection of this data will continue and the Exchange will work collaboratively with the Department of Health in keeping track of these measures.

- While not an audit, the Department of Health collects Medicaid Managed Care Operating Reports (MMCOR) data from its Medicaid Managed Care plans. These reports capture utilization data, membership data, and financial data. The Department of Health also collects encounter data from its Medicaid Managed Care plans, which describes demographics and health status of the populations, reports and monitors service utilization, evaluates access and continuity of services issues, monitor and develops quality and performance indicators, sets rates, performs cost effective analysis, and evaluates various service models and environments. These reporting requirements provide meaningful datasets to assist the Department of Health in its oversight role.

- The Department of Financial Services performs market conduct surveys every five years, and has the ability to request information at any time from health plans through its regulatory authority. The market conduct surveys include review of health plan financial solvency, finances in relation to regulations and accounting standards, medical loss ratio, claims payment, and applicable Department of Labor regulations.

In addition to the above, the NYHBE has engaged MAXIMUS to handle its customer service function, including complaints, grievances and enrollee appeals. MAXIMUS currently handles these issues on behalf of the Department of Health for the Medicaid and Child Health Plus populations, and these efforts will be expanded to include members enrolled through qualified health plans. MAXIMUS will have a process to monitor health plan performance and to collect, analyze, and resolve enrollee complaints. This process will be facilitated by a complaints module at the Call Center that will include a workflow process for complaints to be captured, analyzed, and referred to the appropriate entity for resolution. Before a complaint is referred to a State entity, a trained specialist will first identify if resolution is within Call Center's control.

If the complaint can be resolved before escalation to a State entity such as the Exchange, Department of Financial Services, Department of Health, the specialist will collect relevant information in the complaints module, including the action taken to resolve the complaint. If the complaint cannot be resolved and requires escalation to a State entity, the complaints module contains the workflow functionality to create a referral task for the complaint to be referred to the appropriate State entity for resolution. The complaints module also includes the ability to track, monitor and trend all complaints.

Complaints that are escalated to state agencies will be addressed by in the following manner:

- All eligibility and enrollment appeals will be handled by the NYHBE Appeals Unit.
- Coverage issues relating to commercial plans and CHP will be referred to the DFS Consumer Assistance Unit
- Medicaid coverage issues will be referred to the Department of Health.

The NYHBE will request periodic reports from the various agencies resolving complaints in order to identify trends and address areas of concern.

QHP performance will be monitored for other factors than complaints. They must meet quality and provider network adequacy standards outlined in the Invitation to Participate in the NYHBE. They must also meet administrative requirements specified in the invitation relating to enrollment and member services, marketing, and reporting. QHPs must also adhere to state regulations and will continue to be monitored by DFS and DOH. If the NYHBE finds that a QHP fails to meet any certification standards, they will be issued a notification of the failure to meet the standard(s) which will serve as a warning. Failure to address the deficiency could result in decertification.

4.7 Timeline for QHP Accreditation

As indicated an in the Plan Invitation to Participate in the New York Health Benefit Exchange, accreditation will not be required as a condition of participation in the Exchange in 2014 and 2015. New York has a strong regulatory surveillance process to oversee and monitor health plan compliance and operations. The Exchange will work closely with the Department of Financial Services and the Department of Health to conduct these regulatory functions. The Exchange has determined that it will not require accreditation until 2020, and the Exchange will review its approach to accreditation requirements in 2016.

In July 2012, Exchange staff conducted a review of the current NCQA and URAC accreditation status of health plans licensed in New York State using information publicly available. The results of that review are summarized in an excel file and included as Attachment A. While many New York State plans have achieved full or partial accreditation for some of their lines of business or functional areas, the Exchange has determined that there would not be sufficient time for health plans to come into compliance with this requirement in 2014. In addition, because New York Medicaid has not required Medicaid plans to seek independent accreditation, a decision to enforce this requirement in 2014 would likely restrict their ability to participate in the Exchange in its early years of operation.

Health plans seeking certification as a Qualified Health Plan (QHP) will be required to respond to the Plan Invitation to Participate in the Exchange. Health plans will be asked to indicate whether the health plan is accredited at the time application, and if so, by which entity and for which lines of business or functional areas. The Exchange will verify accreditation with the respective accreditation body.
The Exchange appreciates the flexibility offered in the final regulations to develop a timeline for accreditation that meets the needs of New York's market and consumers. The Exchange will review further guidance on the phased in approach to the establishment of additional accrediting agencies in the future and comply with regulations set forth in 45 CFR 155.1080 and 45 CFR 155.275 as guidelines to further developing a timeline for accreditation, as well as processes for ensuring QHP accreditation.

4.8 Quality Report

For more than a decade, the New York State Department of Health has been collecting and publicly reporting health plan quality ratings for commercial insurance, Medicaid and Child Health Plus. The web portal that is being designed for the Exchange gives New York a new and exciting opportunity to expand this work to Qualified Health Plans and to make the results available to consumers and small businesses in an interactive way at the time they are selecting a health plan for themselves and/or their employees.

The Plan Invitation to Participation in the New York Health Benefit Exchange includes the following:

The DOH monitoring of the quality of care delivered by entities whose products are certified as QHPs (Exchange Participants), will be ongoing and determined through use of a variety of quality, utilization and satisfaction metrics that have been validated, have clinical relevance to the populations served, and are widely in use by health plans serving other populations in New York State. Measuring performance across a wide range of quality metrics will assure Exchange members across the age spectrum and with various health conditions are included in this assessment. This process will also help to establish the DOH's active agenda for improvement and re-measurement. Public reporting of Exchange Participant performance will also be a central feature of the DOH plan for quality oversight.

Outlined below are the DOH expectations related to quality of care and enrollee satisfaction for which the Applicant must adhere:

1. Develop and Maintain a Quality Strategy

Applicants must develop a quality strategy that encompasses all the requirements set forth in 1311(g) of the ACA. This strategy must be implemented, updated annually with progress reported to the designated office of the DOH. The quality strategy should describe how the Applicant will address the following:

(A) improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;

(B) the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education

and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;\PPACACON.005 HOLCPC

(C) the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage;

(D) the implementation of wellness and health promotion activities;

(E) the implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings; and

(F) a description of any current or proposed innovative programs to expand access to mental health services including but not limited to telepsychiatry or consultative services for co-management of common behavioral health conditions in children and adults.

2. Quality Assurance Reporting Requirements

All Applicants will be required to participate in the DOH Quality Assurance Reporting Requirements (QARR). The quality indicators in QARR are comprised of quality of care and utilization of service measures, largely adopted from the National Committee for Quality Assurance (NCQA) Health Care Effectiveness Data and Information Set (HEDIS) with New York State-specific measures added to address health issues of importance to the State. QARR data will be used as a major component of Exchange Participant quality rankings that will appear on the Exchange website and will also be used in identifying clinical best practices, as well as, areas of concern with respect to quality of care and administering the health plan benefit package. The QARR data collected from Exchange Participants will also be posted on the DOH website in eQARR and related publications.

The QARR technical specifications are typically released during the fall season of the measurement year, with reporting of QARR data due on or about the following June 15. The current QARR specifications for reporting year 2013 are posted on the DOH webpage and can be viewed at the following link:

http://www.health.ny.gov/health_care/managed_care/qarrfull/qarr_2013/docs/qarr_specifications_manual_2013.

The Exchange Participants will be required to report quality measures as well as all other required member-level files. QARR reporting will require all Exchange Participants to have:

a) HEDIS Volume 2
b) Programming for all required measures (either in-house capability of through a vendor)
c) An NCQA audit conducted by a licensed audit organization of their QARR data prior to submission to the DOH.

d) A certified CAHPS vendor to administer CAHPS
QARR submissions with respect to Exchange enrollment is anticipated to begin on or around June 2015 for calendar year 2014.

3. Consumer Assessment of Health Care Providers and Systems (CAHPS)

All Exchange Participants will also be required to annually survey a sample of their Exchange eligible members using the standardized CAHPS Health Plan Survey tool. The CAHPS Health Plan Survey allows the DOH to assess many aspects of the members' experience of care, including their access to care and services and their interactions with their providers and health plan. The Exchange Participants may be required to add New York State-specific questions to the tool to aid the state in learning about newly insured's experience and/or to provide additional demographic or clinical detail. Like QARR, the DOH uses CAHPS data to identify any opportunities for improvement and DOH analyses of CAHPS data may require some plans to develop and implement quality improvement strategies.

The initial CAHPs survey for Exchange Participants is anticipated to be scheduled on or around fall of 2014.

4. Quality Improvement Initiatives

The DOH will require Exchange Participants to have the infrastructure in place (or the ability to contract for such services) which allows them to implement their Quality Strategy and related improvement activities as well as participate in a variety of DOH sponsored quality improvement work. This could include administration of member's surveys, offering member education/outreach or incentive programs, offering physician training and/or incentive programs, supporting systematic changes at the practice level and practice level assessments among other things. The Exchange Participants will also be welcome to participate in DOH sponsored statewide improvement initiatives that target issues of importance such as readmissions, coordinated care for members with chronic disease, and other topics.

For Exchange Participants with performance that falls outside normal ranges for quality or satisfaction performance, a barrier analysis and an improvement plan will need to be developed and operationalized once approved by the designated DOH office.

The Exchange will explore ways in which it can collect data to measure the progress on each of these goals.