Quality Working Group Report

District of Columbia Health Benefit Exchange Authority

May 29, 2013

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Introduction

This report is submitted by the Quality Working Group Chair (Kate Sullivan Hare) and Vice Chair (Karen Johnson). The purpose of this report is to outline the recommendations of the Quality Working Group regarding the quality improvement strategies (QISs) and quality reporting activities of the District of Columbia (DC) Health Benefit Exchange Authority (Exchange).

Background

The Patient Protection and Affordable Care Act (ACA) contains a number of provisions aimed at fostering health care quality improvements in insurance marketplaces. To guide the DC Exchange in developing policies related to health plan quality reporting and improvement, the Board charged its Quality Working Group with examining quality ratings for health plans, understanding consumer use of quality ratings for implementation after year one, and specifying the quality information, which is not collected now, that the Exchange should collect going forward to achieve its goal of being a model exchange. For the DC Exchange in 2014, Qualified Health Plan (QHP) issuers will attest to meeting the federal standards. However, no quality data will be displayed on the Exchange web portal this first year due to information technology (IT) limitations.

QHP Issuer Requirements

The ACA requires QHP issuers to implement QISs, enhance patient safety, and publicly report quality data.[1] To participate in an Exchange, QHPs must be accredited by either the National Committee for Quality Assurance (NCQA) or URAC. The U.S. Department of Health and Human Services (HHS) has signaled its interest in having the activities of the Exchange enhance and align with existing quality reporting and display requirements. During the course of its deliberations, the Working Group reviewed a variety of “off the shelf” measures that are readily available in the DC health plan marketplace for reporting purposes. In addition to NCQA accreditation status, readily available measures for all commercial plans in the DC market include Healthcare Effectiveness Data and Information Set (HEDIS) measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience measures. HEDIS measures are the most widely used tool for measuring quality and include 70 measures across four areas: wellness and prevention, chronic disease management, behavioral health, and resource use. The CAHPS survey instrument asks patients how well plans and providers met their needs, such as appointment and care availability and whether one’s provider listens carefully.

Accreditation

To participate in the new Exchange market, health plans must be certified, including accreditation by a national accrediting entity. NCQA is designated as an approved accreditor, as is URAC. States can choose how soon to enforce the accreditation requirement. Some may choose as early as 2013, while others may delay enforcement of this requirement but report

[1] The Patient Protection and Affordable Care Act, Sections 1311(g) and 2717(a).

accreditation status on their web portal. The ACA requires that QHP issuers be accredited on the basis of the local performance of its health plans, including the following:

- Performance across clinical quality measures such as the HEDIS
- Patient experience ratings on a standardized CAHPS survey
- Consumer access
- Utilization management
- Quality assurance
- Provider credentialing
- Complaints and appeals
- Network adequacy and access
- Patient information programs.

These elements required by the ACA mirror those contained in NCQA's accreditation program.

Currently, the NCQA rates 25 plans in the commercial health insurance market that covers the District and the surrounding areas in Maryland and Virginia. These plans received ratings of "Excellent," "Commendable," "Accredited," or "Scheduled" from NCQA.

Phase-In of Exchange Quality Reporting

Last year, HHS provided guidance indicating its intent to pursue a phased approach to quality reporting for all Exchanges and QHP issuers. Other than accreditation standards, HHS does not intend to issue new quality reporting standards until 2016. HHS will be developing a federal quality rating system for Exchanges to use and will solicit public comments during the development process in 2014 and 2015. It is expected that QHP issuers will report data in mid-2016 for care provided in 2015. This rating system is expected to be functional in time for 2016 open enrollment for the 2017 coverage year.

Examples Offered by Other State Exchanges

A number of states have moved quickly in developing their own quality reporting and improvement requirements for QHPs. The analysis of what other states are doing in the quality reporting and improvement area helped inform the Working Group's recommendations. The appendix summarizes state approaches in the quality area.

What Makes the DC Marketplace and Population Unique?

During the first meeting of the Working Group, members commented that DC is unique both in terms of its population and the region that the Exchange will serve.

Working Group members identified several critical health care quality issues in the District, including the following:

- Access to care, especially for the previously uninsured
- Maternal and infant health care, obesity, diabetes, cardiac conditions, asthma, and colorectal cancer
- Mental health and substance abuse
- "Churn" between public and private health insurance
- Ancillary support services
- Tradeoff between quality and cost
- Perceptions related to service quality
- Health disparities.

Members of the Working Group also suggested the following possible roles that the Exchange could play to promote improvements in health quality:

- Ensure that participating health plans have high transparency with clear comparisons.
- Ensure that health plan ratings are based on value for cost and quality.
- Provide consumers with easily understandable apples-to-apples comparisons to make coverage decisions.
- Use community health needs assessments as part of an annual evaluation of area needs.
- Assess how providing information on quality to health consumers affects their health plan choices.

Given these priorities and goals, the Working Group requested that a review of the state of health care quality in the District be provided at the second meeting to inform its deliberations. In response to this request, Dr. Johnson-Clarke, DC Department of Health (DOH), shared key findings from a recent Community Health Needs Assessment report, which was prepared by DOH as part of an application to the Centers for Disease Control and Prevention to fund performance improvement and accreditation activities. The key findings include the following:

- Washington, DC, has made great strides with diabetes care, but DOH knows that further progress is needed.
- Progress has been made in infant mortality; DC is now experiencing 8 infant deaths per 1,000 births.

- Maternity is the leading discharge diagnosis, with psychosis now the third leading diagnosis.

- Heart disease and cancer are the two leading causes of death followed by accidents.

Review of Health Plan Investments in Quality

The ACA establishes a new medical loss ratio rule whereby plans serving the individual and small group market must spend at least 80 percent, and plans serving the large group market must spend 85 percent, of their premium dollars on medical claims and quality improvement or else pay rebates to consumers. HHS specified the following four areas of quality improvement activities that can be included under the medical care component of this ratio and requires that issuers report their quality improvement expenses for these areas:

- Improved health outcomes

- Reduced readmissions

- Improved patient safety

- Improved wellness and health promotion.

David Helms presented data from a recent report issued by The Commonwealth Fund. The report found that insurance companies spent a combined $2.3 billion annually on direct quality improvement activities or an average of $29 per subscriber in 2011, the first year for which the data were available.[2]

The second Working Group meeting also included presentations from Washington, DC, health plan representatives on their quality improvement activities. Below are highlights from those presentations:

- *United Healthcare.* United Healthcare works with NCQA on its premium designation program, which recognizes physicians and specialty centers that meet or exceed quality of care and cost efficiency standards, and is invested in reporting CAHPS and HEDIS measures. The carrier works on reducing health care disparities and addressing culturally diverse processes of care. United Healthcare has tools for Spanish-speaking populations and a "Generations of Wellness" program aimed at African American populations.

- *Kaiser Permanente.* Kaiser has invested $1 billion nationwide in KP Health Connect, an integrated medical record system. One key aim of the medical record system is ensuring transparency and building relationships with primary care physicians (PCPs). Kaiser strives to continually improve its CAHPS and HEDIS scores. The plan has an alert system for when its enrollees need preventive care services. A summary booklet is sent to all members who have a chronic condition, such as asthma, stroke, or diabetes.

[2] Mark Hall and Michael McCue, *Insurers' Medical Loss Ratios and Quality Improvement Spending in 2011* (New York: The Commonwealth Fund, March 2013).

- *CareFirst.* CareFirst launched a Patient Centered Medical Home (PCMH) program in 2011, with 85 percent of all PCPs in Washington, DC, Maryland, and Virginia participating. A key feature of the PCMH program is an IT platform that provides comprehensive member information to care teams, including information about all services provided to a member, whether delivered by a primary care or specialty care physician. The plan has a number of community benefit programs particularly aimed at maternal and child health.

- *Aetna.* Aetna submitted a written summary of its quality improvement work. The summary addressed Aetna's quality goals, current outreach mechanisms, external collaboration, and quality initiative effectiveness measures. Aetna also identified several clinical improvement activities in 2012, such as preventive services reminders, spirometry testing for COPD, breast and cervical cancer screening rosters for physicians, colorectal cancer screening provider roster and iFOBT or FIT test kit initiative, and a diabetes "year in the life" call program.

Design Issues Considered by the Working Group

During its deliberations, the Working Group considered and discussed a range of key design questions, including the following:

- What are the priority areas for quality rating in the DC Exchange marketplace? In addition to clinical measures, should the ratings include delivery of specific preventive services and health plan performance on customer service?

- How might the Exchange best phase in data collection? Do federal requirements for health plans participating in the federally-facilitated marketplaces provide an adequate "de minimus" guideline for the year-one effort?

- What "off the shelf" reports or quality measures should the DC Exchange report on its web portal in early years? NCQA accreditation status? HEDIS measures? CAHPS measures?

- Is the Working Group interested in identifying a core set of measures for plans to report on in later years? Should the Working Group recommend that plans submit an annual report on their quality improvement activities?

- Will plans be allowed to combine Medicaid, commercial, and Exchange populations when reporting quality measures (to offset the low numbers problem for reporting in early years)?

- Should the Exchange allow data collection for quality measure reporting purposes for the three-state metropolitan area (DC, Maryland, and Virginia)?

Working Group Participants

The Quality Working Group comprises representatives from health plans, providers, small businesses, community and consumer advocates, insurance agents, and representatives from the Exchange Board, Advisory Committee, and staff. Table 1 lists them and identifies the organizations they represent.

Table 1. Working Group Participants

Name	Organization
Kate Sullivan Hare (Chair)	DC Health Benefit Exchange Executive Board
Karen Johnson (Vice Chair)	Health Benefit Exchange Advisory Board and United Healthcare
Judy Berman	DC Appleseed
Paul Brayshaw	Individual
Debbie Curtis	DC Health Benefit Exchange
Sarah Dash	Georgetown University Health Policy Institute
Anne Doyle	CareFirst
James Enos	United Healthcare
Rebecca Fitch	Kaiser Permanente
Sam Ghanem	AFG International
Susan Hardy	Kaiser Permanente
Amy Kurz	The Nonprofit Roundtable
Stacy Mills	Adventurous Consulting
Leo Quigley	Individual
Wes Rivers	DC Fiscal Policy Institute
Will Robinson	NCQA
Brendan Rose	DC Health Benefit Exchange
Jill Thorpe	AFrame Digital
Rachelle Toman	DC Primary Care Alliance
Susan Walker	DC Coalition on Long Term Care

Three in-person meetings were held—on March 28, April 24, and May 8—with some members participating by conference call.

Recommendations

In its third meeting, the Working Group reviewed, discussed, and revised draft recommendations that were developed at the end of its second meeting. The revised recommendations were then unanimously approved by the Working Group members present at the third meeting.

1. DC HBX Quality Recommendations for 2014

General Recommendation for 2014

The Exchange should consider assigning the Working Group's recommendations on quality reporting and strategies to an existing or new advisory group for further discussion and

development. This advisory group should include representation from across the spectrum of stakeholder groups, e.g., plans, providers—including essential community providers and public health officials—quality researchers/analysts, health data specialists, consumers, purchaser representatives, and in-person assisters (i.e., navigators, certified application counselors, agents and brokers). Such an advisory group, if formed, would meet on an as-needed basis.

Commentary: The Working Group believes that the Exchange would benefit from using an advisory group on an as needed basis to provide guidance to the Board in coming years. In particular, such an advisory group would inform future decision making regarding selection of quality measures for reporting by QHPs. This advisory group could also provide a conduit for multi-stakeholder input to quality improvement and reporting activities of the Exchange, including the input of consumers. Working Group members expressed their desire to provide the Board with flexibility in how best to obtain this advice, including whether to use an existing or a new group, what the composition of the group should be, and how long the group would serve.

Recommendations Related to Quality Improvement Strategies (QIS) for 2014

- Participating Qualified Health Plan (QHP) issuers will be required to submit a Quality Improvement Plan (QIP) annually starting in 2014.
    - In 2014, the Exchange should collect the QHP issuer's existing QIPs.
    - The Exchange should specify the requirements and format for a standardized QIP to be submitted in 2015, in consultation with health plans and the aforementioned advisory mechanism. These specifications should take into account section 1311(g) of the Affordable Care Act, the Medical Loss Ratio quality reporting requirements (section 2718 of Public Health Service Act), and any future federal guidance.
    - The Exchange should also coordinate with their counterparts in Maryland and Virginia to standardize the information health plans collect and report on tri-state area enrollees in their QIPs.
    - The Exchange should provide an opportunity for public comment on the development of the QIP content and specifications.
- The Exchange will make the QIPs available to the public on the Exchange website.

Commentary: A number of state Exchanges are collecting QIPs from QHPs, with Maryland and Oregon offering two useful examples. Given that the Exchange's web portal will not be able to display quality data until 2015 at the earliest, Working Group members believe that annual collection of QIPs from health plans would be a useful way to guide quality improvement activities. For 2014, the Exchange would collect *existing* QIPs from QHPs. In future years, the Exchange would specify format and requirements for health plan submission of QIPs. The Working Group members strongly supported coordinating with the Maryland and Virginia Exchanges to standardize information collected from health plans across the tri-state area.

Recommendations Related to Quality Reporting for 2014

- In time for the 2015 open enrollment period, the Exchange should work with QHP issuers on the format to report off-the-shelf quality measures—e.g., Consumer Assessment of Health Plan Providers and Systems (CAHPS), National Committee for Quality Assurance (NCQA) or URAC accreditation and Healthcare Effectiveness Data and Information (HEDIS)—based on their existing products most similar to those offered on the Exchange.

    - The Exchange should provide recommendations specifying a) which quality measures will be publicly reported to consumers; and b) how those measures should be reported on the Exchange website.

- The Exchange should provide technical guidance to health plans on an ongoing basis regarding quality reporting.

- The Exchange should review any subsequent federal guidance on the quality rating system for possible implementation and impact on Exchange quality reporting initiatives.

Commentary: Working Group members expressed strong interest in not "reinventing the wheel" with regard to quality measurement and reporting requirements. They considered carefully the use of readily available, "off-the-shelf" quality measures, including CAHPS measures and HEDIS measures, as well as reporting of NCQA or URAC accreditation status.

The Quality Working Group determined that for 2015, QHP quality measure reporting should be based on the QHPs' products that are most similar to the products that will be offered on the Exchange. Depending on enrollment levels during the early years of Exchange implementation, the Exchange may need to have QHPs report quality for similar products offered to a similar population. Working Group members also believe that the Exchange should provide ongoing technical guidance to health plans to facilitate consistent quality measurement and reporting across all QHPs.

2. DC HBX Quality Recommendations for 2015

Recommendations Related to QISs for 2015

During 2015, the Exchange should coordinate with public and private payers and other stakeholders to update QIP requirements to be submitted in 2016 based on any updated federal guidance and the District's public health priorities. These initiatives should address health issues such as health disparities, accident and violence prevention, and clinical issues such as HIV/AIDS prevention and care, tobacco cessation, and perinatal health care.

Commentary: Additional federal guidance related to Exchange quality improvement and reporting activities is anticipated as early as fall 2013. Working Group members acknowledged that the Board will need to be responsive to this guidance moving forward in terms of specifying requirements for health plan QIPs. Working Group members strongly believe that health plan QIPs should reflect the District's public health priorities, including urgent health issues and

high-cost/high-burden health care conditions. Working Group members also expressed strong interest in having QIPs address the issue of health and health care disparities.

Recommendations Related to Quality Reporting for 2015

- The Exchange should implement public reporting to consumers via the Exchange web portal using the same readily available measures as used in 2014.
- The Exchange should explore developing DC Exchange-specific quality reporting requirements and/or a quality rating system for implementation in 2016. In doing so, the Exchange should consider the following:
    - Federal guidance pertaining to the HHS-developed quality rating system
    - Existing measurement systems like NCQA or URAC accreditation, CAHPS, HEDIS, and measures in the Children's Health Insurance Program Reauthorization Act and Medicaid adult core sets
    - Disparities and culturally and linguistically appropriate care
    - The health needs of District residents and urgent DC quality of care concerns
    - How data will be audited, collected and reported to the Exchange
    - How the Exchange would review and provide feedback to plans
    - Burden on plans (e.g., cost) in reporting measures
    - How the rating system would be displayed on the Exchange website (i.e., designed to support improved consumer purchasing)
    - Gaps in current quality and patient experience measures and plans to address those gaps.

Commentary: Working Group members envision populating the Exchange web portal with readily available, health-plan specific "off-the-shelf" measures and indicators of quality (e.g., NCQA accreditation) beginning in 2014 (for 2015 open enrollment) and again in 2015 (for 2016 open enrollment). Working Group members recommend that the Exchange also turn its attention in 2015 to developing specifications for DC Exchange-specific quality reporting requirements. By developing these specifications in 2015, the Working Group signals its strong desire to have the Exchange collect and report quality measurement data from QHPs for the DC Exchange population as soon as possible, preferably in 2016.

3. DC HBX Quality Recommendations for 2016

- Continue implementation of data collection to support quality measures; begin data collection and public reporting of quality measures for the DC Exchange population (as opposed to commercial and/or Medicaid populations) where possible.

- Respond to additional federal guidance and requirements related to Exchange quality reporting and improvement activities.

Commentary: Working Group members determined that recommendations beyond 2016 are not necessary at this time, because a number of factors will affect the Exchange's quality activities in future years.

Appendix. Summary of Selected State Exchange Quality Reporting and Improvement Strategies

State	Reporting	Quality Improvement Strategy
Arkansas	The state will adopt the quality rating standards as provided in federal guidance. Any Arkansas Insurance Department (AID) requests for quality information must be made available upon request. AID will require all QHP issuers to participate and report on the implementation of their quality improvement standards and results no less than quarterly.	AID acknowledges the emerging importance of Arkansas's Payment Improvement Initiative in advancing quality and affordability and recommends that the Partnership engage or require carriers to adopt specific QISs as a condition of having their QHPs certified to be marketed and sold on the Exchange. Any such requirement will not be implemented in the first plan year and will be subject to a future bulletin. AID will notify issuers during the 2014 plan year as the measures are developed. Until the measures are adopted and implemented, AID intends to use CAHPS data results from accredited commercial product lines.
California	Timeline for contractor quality reporting: Commercial HEDIS Fall 2013—Historical (2011) Fall 2014—Historical (2012) Fall 2015—Historical (2013) Fall 2016—QHP specific (2014) Commercial CAHPS Fall 2013—Historical (2011) Fall 2014—Historical (2012) Fall 2015—QHP specific (2014) Fall 2016—QHP specific (2015)	The quality, network and delivery standards will set standards for Exchange's quality activities, including those relating to management, improvement, delivery, reporting, monitoring, auditing, education, training, research, data, and other quality-related activities, as such activities may be amended from time to time by the Exchange.
Delaware	The state will adopt the quality rating standards as provided in federal guidance.	Issuers will be required to participate in state quality improvement work groups intended to standardize QHP QISs, activities, metrics and operations, and technology and data analytics to support coordination. Issuers will be required to participate in and utilize the Delaware Health Information Network data use services and claims data submission services.
Iowa	Issuers that are accredited in the commercial, Medicaid, or Exchange lines of business will be required to agree to	All QHP issuers must submit a quality plan that includes ongoing, written, internal quality assessment of the

State	Reporting	Quality Improvement Strategy
	the release of CAHPS measures, which will be submitted to CCIIO by the accrediting agency and will be displayed with the QHP on the marketplace website. Medicaid CAHPS data will be displayed if commercial market CAHPS data are unavailable. The marketplace website will not display an accredited status for a QHP issuer that does not have any products that have achieved at least "provisional" or "interim" status.	program and guidelines for monitoring and evaluating the quality and appropriateness of care and services provided to enrollees, including accessibility to health care providers and appropriateness of utilization.
Maryland	Survey data, including CAHPS and HEDIS data, will be posted for 2013 open enrollment.	Carriers' QISs must use provider reimbursement or other incentives to improve health outcomes, prevent hospital readmissions, improve patient safety, and implement wellness programs.
New Mexico	In addition to the ACA requirements, carriers will be required to report New Mexico-specific quality information to satisfy New Mexico Department of Insurance quality reporting requirements. Specific guidance on New Mexico quality reporting requirements will be provided within the first year of Exchange operation.	In addition to ACA requirements, an attestation that addresses the required elements from this section will be required. Accreditation status for carriers will meet the quality strategy requirements if the accreditation adequately covers all required elements of the quality strategy requirements. For carriers that have not been accredited, this requirement will apply, and a written QIS must be submitted.
Oregon	Quality ratings will be shown as stars and will be assessed at the carrier level and shown at the plan level for the first 2 years. After 2 years, each plan will have its own quality rating.	Until the federal government issues guidance in 2016, carriers will define quality improvement for themselves.
Washington	Health Benefits Exchange (HBE) will provide a QHP issuer with a form to submit ACA QISs. The submitted strategies will be posted for consumers on the Healthplanfinder web pages. QHP issuers will begin collecting the quality data in the 2014 plan year. HBE will display those measures to consumers during the open enrollment period conducted in 2015 for QHP selections made for the 2016 plan year.	The criterion specifies the collection of information on QHPs; consequently, the criterion cannot be implemented until after QHPs have offered coverage through Healthplanfinder and quality measures have been collected. HBE is in the process of specifying the quality measures to be collected.