America's Health Insurance Plans

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July 17, 2015

Submitted Electronically via: OIRA_submission@omb.eop.gov

Office of Management and Budget
Office of Information and Regulatory Affairs
Attention: CMS Desk Officer

Re: Quality Improvement Strategy Implementation Plan and Progress Report (CMS-10141 and CMS-10540 (OMB control number 0938-0964)) – AHIP Comments

We are writing on behalf of America's Health Insurance Plans (AHIP) to offer comments in response to the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) information collection activity: Quality Improvement Strategy (QIS) Implementation Plan and Progress Report which was released by CMS under the Paperwork Reduction Act of 1995, which provides further guidance on QIS provisions in the 2016 Notice of Benefit and Payment Parameters Rule finalized earlier this year.

Across the country, health plans are delivering high-quality, affordable insurance options to consumers in the new marketplaces. Health plans are currently using a variety of incentive structures with providers including shared-savings, shared-risk models, global payments and other benefit designs to improve quality and affordability. We recommend that HHS, through future guidance and rule making, continue to allow for flexibility of accepted payment methodologies and other incentives, such as those used under accountable care contracts, where health plans reward providers not only for better outcomes, but also for providing value, and increased patient experience and satisfaction.

We support the direction HHS has taken in drafting the technical guidance and user guide where Qualified Health Plans (QHPs) would submit a quality improvement strategy implementation plan or report at the issuer level (5 digit HIOS ID). This strategy reduces the reporting burden on issuers and offers alignment with the QHP application process.

We recommend that HHS take into account specific issues outlined below that impact the Quality Improvement Strategy Implementation Plan and Progress Report completion and submission. Additionally, for detailed comments relating to the QIS Technical Guidance and User Guide please refer to our forthcoming comment letter.

Design and Implementation of the Quality Improvement Strategy

- **We support the annual submission of a Reporting Template beginning one year after the submission of the Plan Template.** Recognizing that this may be the first time consumers have health insurance coverage, HHS should allow plans to modify programs using a continuous quality improvement approach to meet the needs of their members, but report on their strategy once a year, through the QIS Application process using the QIS Reporting Template.

- **We recommend aligning Quality Reporting Strategy and QIS requirements wherever possible across both Federal and State based exchanges to avoid the use of disparate requirements and timelines that would add to cost and burden.** This harmonization should include alignment of product inclusion minimums for the QIS that is consistent with the CAHPS survey minimums (i.e., 500 enrollees or more over two years).

- **QHP issuers would benefit from additional training and resource materials similar to what is offered for the Chronic Care Improvement Program (CCIPs) and the Quality Improvement Project (QIP) for Medicare Advantage.** Such training and materials should include a completed template and scoring for each of the criteria outlined for each element. This will assist QHPs in completing the Form soon after the finalized Technical Guidance and User Guide have been released and would allow QHP issuers to better prepare for QIS implementation and reporting.

- **We caution HHS when evaluating Element 15: Current Payment Model(s) Description that there is no consistent recognized methodology to measure the percentage of provider's payments tied to quality or value.** As we stated in our previous comments to the Notice of Benefits and Payment Parameters Proposed Rule for 2016[1], requesting this information could discourage innovation given the positive performance plans have demonstrated in utilizing alternative approaches to reimbursement and incentive models. Recent studies have attempted to compile such data but this had led to more questions and confusion and the need for additional information and research. Additional work needs to be completed in order to consistently assess and measure the penetration of such payments in the provider community.

Reporting of Quality Improvement Strategy and Specific Elements

- **Given that QHPs will benefit from greater flexibility in designing and implementing QIS, we recommend that QIS reporting be broad and flexible and reporting be focused at the strategy level**. With the focus on high-level reporting, we recommend that QHP issuers have the option to upload attachments which can provide additional

[1] AHIP Notice of Benefits and Payment Parameters Proposed Rule for 2016 Comment Letter, submitted on January 23, 2015 (attached).

details on their program allowing for tables to be copied and pasted into the PDF fillable form.

- **We ask for clarification around expectations for reporting on activities to reduce health and health care disparities.** We understand that addressing health and health care disparities is a component of the QIS, either reported as its own activity or addressed as a part of one of the other activities (topic areas) listed. Since reporting of disparity data may be variable across states and regions, we seek further clarification on expectations of reporting health and health are disparities activities.

  We recommend that if topic area "Implementation of activities to reduce health and health care disparities" is selected, then the link between the topic area and "Activities" reported under Element 22b: Rationale for QIS (Must Pass) must allow for flexibility to implement additional interventions beyond what is included on p. 31-32 of the User Guide. For example if a QHP chooses to address health and health care disparities as the only selected topic, it is possible that a QIS approach would be to utilize data analysis, consumer engagement, navigation tools or cultural competency training which may not be directly linked to increased provider reimbursement or other incentives. If health disparities is selected as a sub-topic to one of the other four topic areas, then Element 23a: Market-based incentive selected, could be left blank if the QIS approach to addressing disparities does not directly link to increased reimbursement or other incentives in the chosen topic area.

- **Element 16: Data Sources. We recommend the deletion of Element 16: Data Sources**. The data sources a QHP uses to identify QHP enrollee population needs or the data sources it will use to monitor QIS progress does not provide relevant information for the use of evaluating a QIS. Issuers use a variety of data sources to evaluate their population and may not specifically pertain to the quality improvement strategy being reported on.

- **Elements 24 C-E: Further clarification is needed to accurately report the information requested under Elements 24c: Baseline results, 24d: Performance period, and 24e: Performance target.** Due to the yearly release of HEDIS data, the completion of these Elements may not be an accurate reflection of the data used to develop the QIS at the time of QIS submission window, currently scheduled from April-May 2016. Because of the submission window timing, the most accurate and audited data available would be for reporting year 2014, which would not give health plans two full years of QHP population data to best assess the population, develop, and report on a quality improvement strategy.

  We recommend HHS allow issuers to submit the QIS in 2016 by including only the measure names and descriptions and allow for the design and development of a market-based incentive quality improvement program during 2016 for implementation in 2017. Issuers could then submit baseline audited results in the QIS Progress Report that looks back over a 2016 baseline period and allow the issuer to set performance targets at that

time. Such an approach would allow sufficient data to be collected on the QHP population and allow establishment of meaningful performance targets. For example, issuers would then submit their first audited performance report by June 2018 looking back at their 2017 performance. Additionally, under Element 24c: Baseline results, we recommend that HHS allow for the flexibility to report both outcome- and process-based measures ensuring flexibility and innovations with QIS strategies.

- **Element 28: QIS Modifications. We recommend issuers have the opportunity to modify performance goals in addition to the allowable modifications listed under Element 28a.** Issuers should have the opportunity to modify performance goals in addition to measures, targets and activities in future years when reporting on progress since this is an important component supporting regular evaluation and innovation when experience shows that previous goals were ineffective and need to be altered to improve program outcomes.

Future Considerations

- **Public display of QIS data.** Section 1311(g) requires that a QHP periodically report that they have implemented a Quality Improvement Strategy and does not indicate that such information be publically reported. As stated previously in this letter, we have recommended that HHS accept a variety of quality improvement strategies to allow for innovation and implementation of programs that help achieve the best outcomes for the patient. Public reporting of the quality improvement strategy may not provide useful information to consumers and could in some instances result in release of proprietary QHP issuer approaches to QIS. Additionally, QIS strategies may not have demonstrated their effectiveness and their impact on quality will need to be evaluated before being made public.

  We understand that HHS intends to make available a subset of the QIS information to promote transparency, yet HHS does not intend to display information considered confidential or proprietary. We recommend that HHS look to the Quality Rating System (QRS) to give consumers information on a standardized set of measures regarding quality of care and enrollee experience. A successful execution of a Quality Improvement Strategy by a QHP issuer should be reflected in improved QRS performance.

  Should HHS choose to move forward with public reporting of QIS information, we request that HHS provide a future public comment period to provide input on making this information publicly available. At such a time, QHP issuers should have had sufficient experience with the Exchange population and a tested reporting structure would be established based on a history of consistent information collection and a process for vetting and validating the information collected.

- **We recommend that HHS consider the development of a glide path for new QHP issuers and established QHP issuers when reporting on a Quality Improvement Strategy.** We recognize that Section 1311(g) does not include language on duration of

QIS reporting. We recommend that HHS revisit the QIS reporting after a 3-5 year period to understand the lessons learned by QHPs and to identify priorities that are common to the Exchange population. This would allow the QHPs to focus their resources on select high priority areas.

As health reform implementation continues to move forward, AHIP and our member plans remain committed to helping ensure successful implementation of the law and the goals of expanding coverage to millions of uninsured Americans and ensuring access to high-quality, affordable care. Our comments and recommendations – based on consultation with health plan policy and operational leaders across the country – are aimed at promoting an affordable and stable insurance marketplace.

We appreciate the opportunity to share these comments and look forward to continue working with you as health reform implementation moves forward.

Sincerely,

Jeanette Thornton
Senior Vice President, Health Plan Operations and Strategy

Aparna Higgins
Senior Vice President, Private Market Innovations

Enclosed: AHIP January 2015 Comment Letter - Quality Improvement Strategy Plan Template and Quality Improvement Strategy Reporting Template (CMS-9944-P)

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January 23, 2015

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services
Attention: CMS-9944-P, CMS Document ID: CMS-10540
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-8016

Re: Quality Improvement Strategy Plan Template and Quality Improvement Strategy Reporting Template (CMS-9944-P) – AHIP Comments

Dear Administrator Tavenner:

We are writing on behalf of America's Health Insurance Plans (AHIP) to offer comments in response to the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) Collection and Reporting of Quality Improvement Strategies (§156.1130) which was referenced in the Notice of Benefit and Payment Parameters Proposed Rule for 2016 and released by CMS under the Paperwork Reduction Act of 1995.

The Notice of Benefit and Payment Parameters Proposed Rule includes important regulatory guidance for qualified health plans (QHPs) quality improvement strategy (QIS) data collection and submission of information including: a phased-in approach to implementation and reporting beginning in 2016; QIS design elements; and related QIS templates used to submit information to HHS on the QIS plan and progress.

Across the country, health plans are delivering high-quality, affordable insurance options to consumers in the new marketplaces. Health plans are currently using a variety of incentive structures with providers including shared-savings and shared-risk models to improve quality and affordability. We recommend HHS align their guidance with current private sector payment methodologies, such as those used under accountable care contracts, where health plans reward providers not only for better outcomes, but also for providing value, and increased patient satisfaction.

We recommend HHS take into account specific issues that impact the design, implementation, and reporting of quality improvement strategy information. These may include:

- Changing populations,
- Reporting on small populations,
- Consistency with state & federal requirements,
- Changing rules and regulations, and
- Having sufficient time to comply with requirements.

Our comments and recommendations below are organized into four topical areas: design and implementation of the quality improvement strategy, reporting of the quality improvement strategy, reporting on disparities, and future considerations. With regard to design and implementation of QIS we reiterate comments we recently submitted to HHS regarding the Notice of Benefit and Payment Parameters Proposed Rule for 2016.

Design and Implementation of the Quality Improvement Strategy

- **We recommend that HHS be flexible and support a breadth of what is considered a Quality Improvement Strategy.** There are a variety of tested and yet to be tested provider and member facing incentives that encourage quality improvement. The focus of improvement strategies should be driven by the needs of the QHP members – this could include areas such as reducing readmissions or improving wellness and health promotion. QHP issuers should be encouraged to leverage known tactics, which may include positive and negative incentives, shared-risk, as well as test new approaches to generate a Quality Improvement Strategy. The following are examples of strategies currently being implemented by health plans; it is not an exhaustive assessment.
  - Programs to reduce Healthcare Acquired Conditions, All-cause Readmissions and Never Events
  - Programs to promote the appropriate use and avoid overuse of prescription drugs, including generics; medication reconciliation; and appropriate use of prescription drugs when contraindications exist, etc.
  - Programs to designate and recognize Centers of Excellence and/or High Performing Providers
  - Administration of the CAHPS Clinician & Group Survey
  - Programs to Promote Smoking Cessation and Weight Loss
  - Programs to Promote Care Coordination, such as transitions of care, follow-up care, discharge planning, prevention and wellness screenings, chronic care management, etc.
  - Appropriate care management programs such as radiology benefit management, which may include overuse measures

- **We support the annual submission of a Reporting Template beginning one year after the submission of the Plan Template.** Recognizing that this may be the first time consumers may have health insurance coverage, HHS should allow plans to modify programs using a continuous quality improvement approach to meet the needs of their members, but report on their strategy once a year though the QIS Reporting Template.

- **We encourage HHS to recognize that QHP issuers need flexibility to define and direct their efforts towards targeted populations and that certain populations may not be appropriate to include under the identified QIS domains.** Thus, we recommend excluding stand-alone dental, pediatric oral health coverage and rural, underserved, and/or provider shortage areas from QIS certification requirements. QIS standards as presently described do not seem appropriate or necessary for such a limited essential health benefit coverage category such as pediatric oral health coverage. Additionally, rural, undeserved, and/or provider shortage areas may lack the infrastructure to support QIS activities as such activities lend themselves to consistent two-way implementation and communication with providers.

- **We propose strengthening the language to support a harmonized reporting strategy for QIS that is consistent across both Federal and State based exchanges to avoid the use of disparate requirements and timelines that would add to cost and burden.**

- **QHP issuers would also benefit from a clear user guide, training, and resource materials, which include detail on the specific elements QIS reviewers will be looking for, soon after the Quality Improvement Strategy guidelines and templates have been finalized, in order for QHP issuers to better prepare for QIS implementation and reporting**.

Reporting of Quality Improvement Strategy

- **Currently health plan accreditation standards include several elements that align with QIS domains and demonstrate at a detailed level quality improvement activities in which plans are engaged.** Please see Appendix A for a crosswalk of QIS reporting domains listed under ACA section 1311(g) and related health plan accreditation program elements. We therefore recommend that HHS allow plans to demonstrate details on their QIS through these accreditation elements.

- **Given that QHPs will benefit from greater flexibility in designing and implementing QIS, we recommend that QIS reporting be broad and flexible and focused at the reporting at the strategy level**. Specifically, HHS should allow a QHP issuers to include a high-level description of the QIS with the focus on:
  - Description of the QIS
  - Priorities of the QIS including conditions of focus
  - Explanation of how the QIS priorities were chosen
  - Explanation of how improvement or success of the QIS is measured

  With the focus on high-level reporting, the template as currently designed, with character restrictions will make it difficult to provide relevant and complete program information. QHP issuers would benefit from having the option of uploading attachments which can provide additional details on their program.

- **We recommend that HHS allow QHP issuers to report on at least one QIS topic area and would caution HHS of the potential network impact and cost impacts of implementing and reporting additional quality improvement strategies. Some plans, such as those with limited networks, will be particularly sensitive to pricing and other market factors. Implementing QIS activities could potentially add to the cost of these plans significantly, which may in turn increase premiums for consumers.**

- **We recommend that the QIS Templates be focused on strategy reporting and elements such as #21 under the QIS Plan Template are not appropriate when reporting at the strategy level.** Section 1311(g) of the Affordable Care Act requests a description of a payment structure that provides increased reimbursement or other incentives for the identified domains and requires periodic reporting of activities that a QHP issuer has implemented, not the reporting of performance measures for such activities. Reporting measures at this level would be duplicative to what is required from QHP issuer accreditation entities and QRS. Additionally, measurement may be difficult in the targeted population as there maybe sample size issues.

  By modifying element #13 to allow for a qualitative description, QHP issuers have the flexibility to utilize measures contained in their provider contracts and provide QHP issuers the ability to tailor performance assessment based on the needs of that provider's patient panel and use existing trending data related to the provider. This would also eliminate the question of measure appropriateness for accountability purposes. For example, some of the HEDIS measures required as part of Quality Rating System (QRS) may not be appropriate for inclusion in a reimbursement model.

- **We recommend modifying the Reporting Template to include only new program or program improvement information narratives and eliminate element #16.** Our recommendation to eliminate element #16 "*Analyze Progress Using Baseline Data, as Documented in Plan Template*" would coincide with our previously stated recommendation to eliminate element #21 from the QIS Plan template since we feel that the inclusion of measures would be duplicative under the Quality Improvement Strategy and does not support the intent of Section 1311(g).

- **Under the QIS Plan Template element #14, we recommend HHS exclude reporting on the percentage of all payments to providers that rewarded quality and value.** As we stated in our comments to the Notice of Benefits and Payment Parameters Proposed Rule for 2016, requesting this information could discourage innovation given the positive performance plans have demonstrated. Currently no consistent recognized methodology exists to measure the percentage of provider's payments tied to cost and quality. Recent studies have attempted to compile such data but this had led to more questions and confusion and the need for additional information and research. Additional work needs to be completed in order to consistently assess and measure the penetration of such payments in the provider community.

Reporting on Disparities

- **We seek further clarification from HHS concerning the implementation of activities to reduce health and health care disparities and specific differences between ACA Section 1311(g), the proposed rule and the proposed QIS Plan and Reporting templates.** Specifically, we seek clarification on QIS implementation of activities to reduce health and health care disparities as it relates to the requirement to include this activity under a "Topic Area Selection" in the Quality Improvement Strategy Plan Template in addition to one of the four reporting domains. This information conflicts with the proposed rule language which states that a QHP issuer's QIS would address "at least one of the topics specified in section 1311(g) of the Affordable Care Act".

- **We are supportive of allowing plans to report on at least one topic under section 1311(g) and recommend a phased-in flexible approach to the reporting on activities to reduce health and health care disparities.** Health plans have demonstrated a longstanding commitment to reduce health care disparities for quality improvement; these efforts have evolved into multi-level approaches to effectively address a complex issue that stems beyond our health care system. A phased-in approach to the reporting of heath care disparity reduction activities will allow for time to develop incentive strategies for the exchange populations. Currently many health plans are at various stages in designing their approaches and are assessing a feasibility plan which is determined by local market characteristics, assessment of capacity, and the ability to tie a reimbursement structure or other incentive program to a health care disparity strategy.

  Additionally, QHP issuers may not have sufficient data to report on disparities activities as outlined in the QIS Plan Template, either because the population is too small or because the QIS program for a targeted domain may not currently include incentives to reduce health care disparities.

- **We recommend that HHS reformat and rename QIS Plan Template element #17 "*Reducing Health and Health care Disparities*".** This would entail removing #17 to *Priorities of the Quality Improvement Strategy*" and include subset "17a" describing the priorities under the specific domain selection and subset "17b" explaining the details of priorities to address disparities.

Future Considerations

- **We do not recommend public display of QIS data.** Section 1311(g) requires that a qualified health plan periodically report that they have implemented a Quality Improvement Strategy and does not indicate that such information be publically reported. As stated previously in this letter, we have recommended that HHS accept a variety of quality improvement strategies to allow for innovation and implementation of programs that help achieve the best outcomes of the patient. Public reporting of the quality improvement strategy may not provide useful information to consumers and could in some instances result in release of proprietary QHP issuer approaches to QIS. We recommend that HHS look to the Quality Rating System (QRS) to give consumers information on a standardized set of measures regarding quality of care and enrollee

experience. A successful execution of a Quality Improvement Strategy by a QHP issuer should be reflected in improved QRS performance.

If at such a time public reporting is revisited, we request that HHS provide a future public comment period to provide input on making QIS information available to the public. Additionally, at such a time, QHP issuers should have had sufficient experience with the Exchange population and a tested reporting structure would be established based on a history of consistent information collection and a process for vetting and validating the information collected.

- **We recommend that HHS consider the development of a glide path for new QHP issuers and established QHP issuers when reporting on a Quality Improvement Strategy.** We recognize that Section 1311(g) does not include language on duration of QIS reporting. We recommend that HHS revisit the QIS reporting after a 3-5 year period to understand the lessons learned by QHPs and to identify priorities that are common to the Exchange population. This would allow the QHPs to focus their resources on select high priority areas.

As health reform implementation continues to move forward, AHIP and our member plans remain committed to helping ensure successful implementation of the law and the goals of expanding coverage to millions of uninsured Americans and ensuring access to high-quality, affordable care. Our comments and recommendations – based on consultation with health plan policy and operational leaders across the country – are aimed at promoting an affordable and stable insurance marketplace.

We appreciate the opportunity to share these comments and look forward to continue working with you as health reform implementation moves forward.

Sincerely,

Carmella Bocchino

Carmella Bocchino
Executive Vice President

APPENDIX A: Proposal for Quality Improvement Strategy Reporting Required by Section 2717 and 1311(g)

Background on Health Plan Quality Reporting Requirements

ACA Sec. 1311(g) requires plans participating in the Marketplace periodically report on activities that implement a payment structure that provides increased reimbursement or other incentives aimed at four domains: improving health outcomes, including though the use of the medical home model; reducing/preventing hospital readmissions; improving patient safety and reduce medical errors; improving wellness and health promotion; as well as reducing health and health care disparities.

Today health plans utilize varying benefits and health care provider reimbursement structures to address the quality improvement strategy domains outlined in Section 1311(g). We also note that Section 2717 of the ACA does not require accreditation but subsequent guidance §155.1045 and §156.275 outline an accreditation timeline indicating that QHP issuers under the Federally-facilitated Exchange must be fully-accredited by their fourth year of QHP certification, though State-based Exchanges and multi-state plans may follow a variety of timelines for QHP certification and accreditation, thus those health plans that are not accredited would be required to provide additional detail as part of their QIS reporting.

Please note that the specific examples listed below are not meant to be exhaustive or mandatory; given all may not be relevant to a specific health plans' strategies. For example, while a health plan may have "a pay-for-performance program," "bundled payments" or "population management contracts," those payment structures may not be directly related to or capable of impacting the reporting domains. Similarly, if a tiered network was selected solely on the basis of patient safety indicators, members' use of the tiered network may not have a direct impact on wellness and health promotion activities.

Proposal for Quality Improvement Strategy Reporting			
Reporting Domains	**Accredited Health Plans** (*See 2nd grid for Reporting Domain and Accreditation Alignment*)	**Non-Accredited Health Plans and Quality Improvement Strategies not linked to health plan accreditation**	
	Narrative description of QIS with respect to coverage benefits and health care provider reimbursement structures plus validation of accreditation	**Narrative description of QIS with respect to coverage benefits and health care provider reimbursement structures plus standard format description**	
For all reporting domains: • Improve Health Outcomes • Preventing Hospital Readmissions • Improve Patient Safety and Reduce Medical Errors • Wellness and Health Promotion Activities • Personalized wellness and prevention services and risk assessment for:	Health plans to describe coverage benefits that improve health outcomes through the use of: - Tiered networks - Designated Centers of Excellence and or High Performing Providers - Programs to reduce Health Acquired Conditions, All-cause Readmissions and Never Events - Other health plan population specific initiatives	Health plans to describe coverage benefits that improve health outcomes through the use of: - Tiered networks - Designated Centers of Excellence and or High Performing Providers - Programs to reduce Health Acquired Conditions, All-cause Readmissions and Never Events - Other health plan population specific initiatives	Health plans submit information using a standard format that consists of the following areas: **Description of the QIS** • Identify the medical condition, target population or use of incentives or benefit redesign and any exceptions (could easily be a drop down menu with a list) **Priorities of the QIS** • Specify the goals of each strategy; such as reduce ER visits or hospitalization; improve

APPENDIX A: Proposal for Quality Improvement Strategy Reporting Required by Section 2717 and 1311(g)

– smoking cessation, – weight management, – stress management, – physical fitness, – nutrition, – heart disease prevention, – healthy lifestyle support, – diabetes prevention	Health plans to report on healthcare provider reimbursement structures that improve health outcomes through the use of: - Pay-for-performance programs - Population management contracts (e.g. Patient-centered medical homes, accountable care models) - Bundled payments for specific services or care episodes - Care coordination, care transition, and best practices identified - Linkages of care quality, effective care delivery and the resulting care efficiencies where appropriate. - Other health plan population specific initiatives	Health plans to report on healthcare provider reimbursement structures that improve health outcomes through the use of: - Pay-for-performance programs - Population management contracts (e.g. Patient-centered medical homes, accountable care models) - Bundled payments for specific services or care episodes - Care coordination, care transition, and best practices identified - Linkages of care quality, effective care delivery and the resulting care efficiencies where appropriate. - Other health plan population specific initiatives	medication compliance; etc. **Explanation of how QIS Strategies were chosen** • Provide information on how condition or population was selected; such as wide variation in provider practice, consumer demand, high prevalence/impact conditions **Explanation of how improvement or success is measured** • List specific metrics for each strategy; # of patients participating, # completing the program, patient experience survey; metrics based on the goals previously identified • Information about any exclusions, data limitations and standardization needs **Patient outreach** • Specify how patient input is obtained for the design and improvement of the strategy; how patients are made aware of the program
Reduce Health and Health Care Disparities • Language series • Community outreach • Cultural competency trainings	*(Reporting reducing health disparities is not required under Section 2717, but is required for health insurance exchange plans reporting QIS under Section 1311(g)).*	*(Reporting reducing health disparities is not required under Section 2717, but is required for health insurance exchange plans reporting QIS under Section 1311(g)).*	*(Reporting reducing health disparities is not required under Section 2717, but is required for health insurance exchange plans reporting QIS under Section 1311(g)).*

APPENDIX A: Proposal for Quality Improvement Strategy Reporting Required by Section 2717 and 1311(g)

Crosswalk between QIS Reporting Domains and Existing Accreditation Requirements			
Reporting Domains	**Included in Existing Accreditation Requirements** NCQA, URAC and AAAHC accreditation programs align with Federal and State Health Insurance Exchange plan requirements, and are deemed as Qualified Health plan accreditors. Their respective programs contain elements which align with the outlined reporting domains of 1311(g).		
	NCQA 2015 Accreditation	**URAC Accreditation 7.1**	**AAAHC 2014 Accreditation**
Improve Health Outcomes, including though the use of the medical home model (Section 2717(a)) • Quality reporting • Effective case management • Care coordination • Chronic disease management • Medication and care compliance initiatives	- Quality Management and Improvement o QI-7: Complex Case Management o QI-8: Disease Management o QI-9: Clinical Practice Guidelines o QI-10: Continuity and Coordination of Medical Care o QI 11: Continuity and Coordination of BH and Medical Care - Sample HEDIS measures: o Antidepressant Medication Management o Persistence of Beta-Blocker Treatment after a Heart Attack o Comprehensive Diabetes Care o HbA1C Poorly Controlled o Medical Assistance with smoking and tobacco use cessation - NCQA also offers: o NQCA PCMH 2011 and PCMH 2014 recognition o Disease Management Accreditation o Case Management Accreditation o PQ Certification	- Quality Management o P-QM 1-9 - Health Plan Operations o P-OPS 7: Care Coordination Regarding Medication Safety o P-OPS 8 - P&T Formulary Development - Measurement Reporting to URAC o P-RPT 1-2 - URAC also offers: o Patient Centered Health Care Home (PCHCH) Achievement Program o Patient Centered Medical Home Certification Standard 2.0 o Care Management Accreditation o Disease Management Accreditation o Pharmacy Quality Management Accreditation	- 04 Case Management and Care Coordination - 05 Quality Improvement and Management - 06 Clinical Records and Health Information - 07 Environment of Care and Safety - 09 Behavioral Health Services - AAAHC also offers: o Medical Home Accreditation o Medical Home On-Site Certification
Preventing Hospital Readmissions • Comprehensive program for hospital	- NCQA plans to update Health Plan Accreditation to reflect these	- URAC Health Plan Accreditation plans to incorporate measures and	- 04 Case Management and Care Coordination

discharge • Patient-centered education and counseling • Comprehensive discharge planning • Post discharge reinforcement by health professional	elements. - Existing Accreditation looks more toward the collection or hospital discharge data, and measurement of admissions and readmission rates, not education or discharge planning	standards that meet quality care and reporting for preventable hospital admissions. - Existing URAC Accreditation includes this element as it relates to MLR expense	
Improve Patient Safety and Reduce Medical Errors • Use of best clinical practices • Evidence based medicine • Health information technology	- Addresses Patent Safety under QI and UM o QI-1: Element A: Quality Improvement Program Structure o QI-9: Clinical Practice Guidelines o UM-13: Procedures for Pharmaceutical Management (re. interactions and recalls) o CR 6: Ongoing Monitoring and Interventions o MEM-6: Element A: Innovative Technology - NCQA also offers: o Health Information Products Certification	- Health Plan Operations o P-OPS 7: Care Coordination Regarding Medication Safety o P-OPS 8 - P&T Formulary Development - Health Unitization Management Accreditation o HUM 24 – Prospective Review Patient Safety - URAC also offers: o Health Information Technology Accreditation	- 04 Case Management and Care Coordination
Wellness and Health Promotion Activities • Personalized wellness and prevention services and risk assessment for: – smoking cessation, – weight management, – stress management, – physical fitness, – nutrition, – heart disease prevention, – healthy lifestyle support, – diabetes prevention	- Use of Health Appraisals o MEM-1: Health Appraisals, Element A, HA Components (Assessment completed) o MEM-1: HA, Element C, HA Scope (includes: smoking sensation , physician activity, healthy eating, and stress) o MEM-1:HA, Element D, HA Results (references given to improve or aide results) o MEM-2: Self-Management Tools, Element A, Topic of Tools (addresses: smoking cessation, BMI, stress, physical activity, healthy eating)	- Member Relations o P-MR 9: Health Risk Assessment Tool - URAC offers: o Wellness Accreditation	- 04 Case Management and Care Coordination - 08 Health Education and Wellness Promotion

	o MEM 8: Support for Health Living - Also addressed under QI - Does not directly address the others, only through measures collected for accreditation under HEDIS. For example: o Cholesterol management for patients with cardiovascular conditions o Comprehensive Diabetes Care o HbA1C Poorly Controlled, and o Medical assistance with smoking and tobacco use cessation o Breast Cancer Screening o Cervical Cancer Screening o Colorectal Cancer Screening o Childhood immunization status o Prenatal and Postpartum Care o Flu shots for adults (50-64) o Flu shots for older adults - NCQA also offers: o Health Information Products Certification o Wellness & Health Promotion Accreditation and Certification o Diabetes Recognition Program		
Reduce Health and Health Care Disparities • Language series • Community outreach • Cultural competency trainings	- Quality Management and Improvement o QI-4: Availability of Practitioners, Element A, Cultural needs and Preferences o QI-1: Program Structure, Element A, Analyzing existence of healthcare disparities o QI 7: Element A, Population Assessment o RR 3: Interpreter Services	- Consumer Protection and Empowerment o Core 40 – Health Literacy - Member Relations o P-MR 6 – Health Literacy to Support Consumers	- 04 Case Management and Care Coordination - 05 Quality Improvement and Management

	o RR 4: Element I, Usability Testing (F5-Directories in additional languages) - Includes focus groups as needed as well as the use of training tools - NCQA also offers: o Multicultural Health Care Distinction		