



HEALTH PLAN QUALITY IMPROVEMENT STRATEGY REPORTING UNDER THE AFFORDABLE CARE ACT: IMPLEMENTATION CONSIDERATIONS

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April 2012

ABSTRACT: The Affordable Care Act calls for the U.S. Secretary of Health and Human Services to issue quality improvement reporting requirements for employer group health plans, including self-insured plans, and individual plans, as well as for qualifying plans in health insurance exchanges. Health plans will need to report on their quality improvement activities regarding plan or coverage benefits and provider reimbursement structures that: improve health outcomes, prevent hospital readmissions, improve patient safety and reduce medical errors, and implement wellness and health promotion activities. Mindful of the opportunity to leverage existing plan reporting tools and achieve administrative efficiencies, this report summarizes key features of the eValue8 Health Plan Request for Information, National Committee for Quality Assurance accreditation, and Medicaid’s external quality review process. The authors offer the National Quality Strategy as a framework for quality improvement reporting requirements to align efforts among health plans, health care providers, and health care purchasers.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff. To learn about new Commonwealth Fund publications when they become available, visit the Fund’s Web site and [register to receive e-mail alerts](#). Commonwealth Fund pub. no. 1592.

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Additional input for this report was provided through a stakeholder roundtable held on July 8, 2011. Roundtable participants are listed in [Appendix A](#).

Editorial support was provided by Martha Hostetter.

EXECUTIVE SUMMARY

A provision of the Patient Protection and Affordable Care Act (Affordable Care Act) requires health plans to submit reports each year demonstrating how they reward health care quality through market-based incentives in benefit design and provider reimbursement structures. By spring 2012, the U.S. Secretary of Health and Human Services (HHS) is expected to develop requirements for health plans to report on their efforts to: improve health outcomes, prevent hospital readmissions, ensure patient safety and reduce medical errors, and implement wellness and health promotion activities. Both employer group health plans, including self-insured plans, individual market plans, and qualified health plans sold through the insurance exchanges are required to submit such reports ([Appendix B](#)).

This report outlines key considerations for implementing these provisions of the health reform law. After reviewing health plan strategies that may positively affect health and health care quality, we propose a framework that can be used to identify and develop measures and reporting requirements. Next, we review current health plan assessment methods that may inform specifications to be developed by the HHS secretary. Finally, we offer a set of recommendations for the design of health plan reporting requirements.

Many health plans implement benefit designs that aim to improve health care outcomes, quality, and value. By benefit design, we mean the use of cost-sharing and incentives across a range of product options; these are distinct from coverage rules, which are determined by federal guidance on the definition of essential health benefits. Examples of innovative benefit practices include the selection of high-performing physicians, physician groups, and hospitals based on various quality and efficiency metrics; the use of decision support to guide preference-sensitive treatment choices; and the use of patient reminders and incentives to encourage enrollees to receive preventive screenings.

In addition, some health plans use their contracts with providers to encourage high-quality, high-value care. Such payment models include performance-based contracts that link payment to the achievement of certain quality and/or efficiency thresholds. A limited number of purchasers attempt to bundle payments for episodes of care. Some primary care medical home or accountable care contracts augment a primary care case management fee with prospective gain-sharing for achieving reductions in the total cost of health care or achieving other performance targets. Among hospitals, the Premier

program, Medicare Advantage STARS program, and the Centers for Medicare and Medicaid Services' (CMS) hospital value-based purchasing program have accelerated adoption of quality- and outcomes-based contracts with payments linked to performance, public reporting, or participation in regional and multistate collaboratives.

Framework for Quality Improvement Reporting Requirements

In considering a framework to meet reporting requirements outlined in the Affordable Care Act, there are significant opportunities to align with the National Quality Strategy (NQS) in pursuit of improving population health, improving care experiences, and controlling per capita costs. Common domains across these initiatives and the NQS priorities reflect a broad view of quality improvement:

- making care safer by reducing harm;
- engaging patients and family as partners in their care;
- promoting effective communication and care coordination;
- promoting the most effective prevention and treatment practices;
- working with communities to enable healthy living; and
- making care more affordable through new health care delivery models.

As illustrated below, there are relevant benefit design and provider reimbursement features that could be grouped under each priority area as a way to reinforce and implement a health plan's quality improvement strategies. To guide the selection of quality improvement reporting requirements for health plans' benefit design and provider reimbursement strategies, the following criteria should be considered:

1. conforms to statutory requirements;
2. consistent with the National Quality Strategy and other federal programs;
3. likelihood that measured activities and/or reporting will contribute to improvement of health outcomes;
4. builds upon existing documentation and reporting systems where possible in order to limit additional burden on plan reporting or provider data collection;
5. has face validity to consumers, plans, providers, and policymakers; and
6. submitted information can be verified.

Measuring Health Plan Efforts to Improve Quality

Health plan performance is measured through an increasing array of standardized performance measures assessing preventive care, clinical processes, and intermediate outcomes (e.g., blood pressure or cholesterol levels) as well as care experiences and outcomes (e.g., functional status). CMS requires health plans participating in Medicare Advantage to report many such performance measures. In addition, many of these measures are required by states for Medicaid managed care programs or under regulatory requirements promulgated through states' health departments or insurance commissioners.

Many health plans attempt to improve performance by rewarding and reimbursing providers for a range of activities including care coordination, care and case management, medication reconciliation and compliance, or development of primary care medical homes. In addition, health plans may seek to improve value through benefit designs that provide incentives for members to choose evidence-based treatments (e.g., by waiving copayments) or select providers with higher performance ratings. Health plans may also offer decision-support tools to help members make informed treatment choices.

There are a variety of approaches to assessing health plan performance. An employer-sponsored tool developed and maintained by the National Business Coalition on Health (NBCH), eValue8 gathers information through a standard, annual, request-for-information survey. It gathers information about health plan performance in critical areas such as prevention and health promotion, adoption of health information technology, member and provider support, disease management, provider performance measurement and rewards, patient safety, pharmaceutical management, and behavioral health.

The National Committee for Quality Assurance (NCQA) and URAC accredit health plans, with NCQA accreditation more commonly required by large employers. NCQA-accredited health plans are reviewed against more than 60 standards and must report on their performance in more than 40 areas in order to earn accreditation. NCQA uses a unified set of standards for health maintenance organizations (HMOs), managed care organizations (MCOs), preferred provider organizations (PPOs), and point of service (POS) plans, relies extensively on performance measures in accreditation decisions, and publishes a health plan report card on its Web site.

Medicaid managed care's external quality review is another health plan assessment approach, although it does not directly report on benefit and provider reimbursement strategies. Furthermore, the structure and content of this assessment may

vary considerably, depending on the review organization. While reporting standardized performance measures is common and routine for most HMO and POS plans, and for many PPO plans, detailed assessment and reporting of health plan activities related to provider payment and benefit design strategies are not.

Uses of Reported Information from Health Plans

The various audiences for health plan quality information have unique needs, which should be taken into account in the design and implementation of reporting requirements. These requirements should also address various applications of the information, such as oversight and monitoring, quality improvement, public reporting, and decision support. The audiences for health plan quality information include:

1. state oversight and health information exchange boards, as well as governance and operational entities;
2. health plans;
3. consumers;
4. employers; and
5. physicians, hospitals, and provider organizations.

Purchasers rely on both NCQA accreditation and eValue8 to collect program and service operations data and, to varying degrees, to assess the effectiveness of a health plan's quality improvement programs. Consumers might use quality information to make decisions about choice of provider, choice of treatment, and potential out-of-pocket costs. The quality reporting system should assess whether health plans make information about the performance of individual physicians and hospital service lines available to their members; such information is becoming more widely available, and research has shown that consumers prefer it to performance information aggregated at physician group or hospitalwide levels.

Key Considerations

At a roundtable meeting supported by The Commonwealth Fund and convened by AcademyHealth, experts, stakeholders, and government officials discussed current approaches to health plan quality improvement reporting and generated recommendations for implementing reporting requirements under the Affordable Care Act ([Appendix A](#)).

- **Recommendation 1.** Move ahead strategically, balancing parsimony, standardization, and innovation by emphasizing dimensions of care delivery and

payment reform that align with the National Quality Strategy and hold the greatest promise for delivering significant improvements in health outcomes and value. Use standardized outcome measures to set performance expectations, but do not overly prescribe interventions that could have the unintended consequence of stifling innovation. Support the development and use of metrics that may fill NQS measurement gaps, such as those assessing care coordination, patient-reported outcomes, and affordability.

- **Recommendation 2.** Focus on outcomes, when they are available; report on improvement strategies only when outcomes reporting is not yet feasible. Consider the evidence base for health plans' improvement strategies as well as the current state of performance measurement. Balance consistency and reporting burden with opportunities to refine the underlying measures for broad domains that are delineated in the statute, such as wellness and prevention. Use process measures and indicators of improvement programs' results, effectiveness, and reach when outcomes are not available and in cases where they may be helpful in illuminating issues such as incentive design, disparities in care, or risk segmentation.
- **Recommendation 3.** Recognize and address the information needs of diverse users of quality reporting, including state oversight and exchange boards, governance and operational entities, health plans, consumers, employers, and providers. The information and detail required for oversight and quality improvement are different than those for public reporting and accountability. Likewise, consumers want actionable information and tools to support decisions about their choice of health plans, doctors, hospitals, and treatment. In addition, consumers may have different expectations about transparency than do other users.
- **Recommendation 4.** Support consistent implementation across health plans and health insurance exchanges to foster administrative efficiency and ensure benchmarking capabilities across states. Offer templates and reporting formats to promote standardization across states as well as across the public and private sectors. Promote consistency in the information available to consumers and the requirements for multistate health plans.
- **Recommendation 5.** Balance value against the resources required to implement quality reporting by aligning efforts with other federal programs and leveraging existing accreditation and reporting tools. Align with other measurement and reporting requirements of the Affordable Care Act and other federal initiatives such as the incentives for "meaningful use" of electronic medical records and the Medicare Shared Savings Program.

- **Recommendation 6.** Invest in initial testing and develop a learning infrastructure for evaluation and improvement of reporting over time, while keeping an eye on unintended consequences. Align public and private value-based purchasing initiatives to facilitate knowledge transfer and adoption of best practices. Integrate qualitative feedback from regulators, health plans, providers, and consumers; in particular, elicit feedback from consumers on how they are using the available information and what other information they want. Monitor the potential for unintended consequences and the implications for future policy.
- **Recommendation 7.** Review and update quality reporting requirements on a regular basis to ensure their relevance and alignment with emerging federal requirements. Provide criteria for the frequency and scope of such reviews to capture new evidence and spread innovative practices. Over time, more robust measures of health care outcomes may emerge from electronic health records, new coding requirements, and health information exchange.

HEALTH PLAN QUALITY IMPROVEMENT STRATEGY REPORTING UNDER THE AFFORDABLE CARE ACT: IMPLEMENTATION CONSIDERATIONS

INTRODUCTION

Section 2717 of the Affordable Care Act includes a set of reporting requirements for employer group health plans, including self-insured plans, as well as individual market plans. By March 2012, the Secretary of the U.S. Department of Health and Human Services (HHS), in consultation with experts in health care quality and other stakeholders, is to develop requirements for all health plans to report on their quality improvement activities with respect to benefits and provider reimbursement structures that:

- (A) improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model as defined for purposes of section 3602 of the Patient Protection and Affordable Care Act, for treatment or services under the plan or coverage;*
- (B) implement 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;*
- (C) implement 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; and*
- (D) implement wellness and health promotion activities.*

All group health plans and health insurance issuers offering group or individual coverage must submit an annual report to the secretary and their enrollees on whether the plans satisfy the elements described above. Section 1311 of the reform law also calls for rewarding quality through market-based incentives. The secretary is to develop a similar set of reporting requirements for qualified health plans sold through the insurance exchanges. Further, as a condition of certification in a health insurance exchange, qualified health plans are required to demonstrate they have *implemented* a quality improvement strategy, which is described similarly in terms of the plan's reimbursement and incentive structures. In addition, plans in the exchanges will have to report on their activities aimed at reducing health and health care disparities. (See excerpts of Sections 2717 and 1311 in [Appendix B](#).)

Other statutes and regulations require the secretary to establish quality reporting requirements for various programs, including the National Quality Strategy, Medicare Shared Savings Program for accountable care organizations, the Physician Compare public reporting Web site, hospital value-based purchasing, and the incentive program to encourage meaningful use of electronic medical records. HHS seeks to have a coherent and consistent framework for capturing and reporting quality information wherever possible, while conforming to the specific requirements of relevant statutes and prior regulations. There are significant opportunities to align measurement requirements across these programs to focus health plan and provider activities in quality and population health improvement while minimizing administrative burdens.

This report examines current practices in reporting health plan quality improvement strategies, the types of such quality improvement programs, and health plan assessment methods. The authors first present assumptions that frame the interpretation of Sections 2717 and 1311 of the Affordable Care Act and then describe benefit designs and provider reimbursement strategies that may positively affect health and health care quality. Finally, the report concludes with recommendations for health plan reporting, which were substantially informed by discussions among stakeholders and experts at a meeting on July 8, 2011. These recommendations are the opinions of the authors and do not represent any consensus from the attendees at that meeting.

FRAMING ASSUMPTIONS

The Affordable Care Act called for the development of a National Quality Strategy and includes many provisions for activities to measure, report on, and promote the quality and outcomes of care. The provisions discussed here (Sections 2717 and 1311) represent only a small part of overall activities in the public and private sectors to advance health care quality. Therefore, we narrowly interpreted the provisions as focusing only on the specific strategies and domains articulated in the legislative language. Strategies for educating consumers and public reporting on quality and outcomes were considered largely out of scope for this report.

A second framing assumption addressed the scope of the quality improvement strategies covered by the terms “coverage benefits” and “provider reimbursement strategies.” While benefit design is the most obvious interpretation of the first term, health plans also often provide covered individuals with other important benefits and services, which may be relevant and appropriate for reporting. For example, member risk stratification and engagement through health management programs that improve care coordination and reduce readmissions (one of the domains called for in the legislation) can also serve to differentiate plan performance.

A third framing assumption is how these requirements affect Employee Retirement Income Security Act (ERISA) plans. For the purposes of this report, it is assumed that self-insured employers would not be subject to the reporting requirements; however, the insurance entities that they contract with to implement their insurance products would be included in the reporting requirement.

HEALTH PLANS' BENEFIT DESIGN AND PROVIDER REIMBURSEMENT STRATEGIES

Many health plans have implemented benefit design and provider reimbursement strategies that may significantly improve health care quality, outcomes, and value. The following illustrative examples provide context for a quality improvement reporting framework. There are varying amounts of evidence on the effectiveness of these strategies.

By benefit design, we mean the use of cost-sharing and other incentives across a range of health plan options, distinct from coverage rules, which are determined by the definition of essential benefits. The cost-sharing levels among health plan product designs offered through the exchanges will be established through defined actuarial values for each of four levels (platinum, gold, silver, and bronze). Current benefit designs seek to influence members' provider selection, treatment choice, engagement in care management or coaching, use of preventive and health promotion services, and prescription drug adherence. Examples of such benefit designs include:

- Incentives to choose high-performing physicians, physician groups, and hospitals based on various quality and efficiency metrics. These may focus on primary care and/or specialty physicians, as well as certain high-cost hospital services such as cardiac or orthopedic care.
- Reference pricing, or fixed-dollar coverage for specific procedures or narrowly defined episodes of care. This approach has garnered interest among large purchasers as a vehicle to drive price transparency and differentiate among provider networks based on value.
- Use of decision support to guide a member's choice of an elective service among evidence-based options, linked to a patient's risk tolerance, preference, outcomes expectation, and disease state or stage of illness. Copayment waivers or coinsurance reductions may accompany a patient's engagement in using decision tools, independent of the actual course of treatment.
- Employers and health plans commonly offer financial incentives to promote participation in care management or coaching to reduce health risks.

- Patient reminders and incentives promote use of preventive screenings. Point accumulators, reduced out-of-pocket costs, or other rules may reward adherence or achievement of biometric goals such as a healthy body mass index or appropriate lipid levels, or enrollment in a smoking cessation program.
- Incentives are also commonly used to engage members in completing health risk appraisals or using online self-care tools (e.g., educational courses, weight management, or stress reduction).
- Condition-specific incentives may be targeted to reduce financial barriers to obtaining medications for chronic conditions or diagnostic screenings. These may be triggered by diagnosis alone or be tied to participation in a health management program.

Health plans also use provider reimbursement strategies to attempt to improve care. Most private plans use fee-for-service reimbursement, typically based on the Medicare resource-based relative value scale. Select services such as maternity care are commonly reimbursed as case rates. To a lesser degree, but with growing interest, health plans are contracting with providers for episode payments that are intended to promote care coordination and management of a course of treatment for a defined condition.

Managed care plan payments may include capitation, either for primary care or, less commonly, specialty contact capitation, whereby an organized multispecialty group or independent practice association accepts full or partial risk for managing the cost of services within the budgeted capitation. Such payments may also be risk-adjusted. The capitated entity may in turn pay its providers through a per member per month schedule, discounted fee-for-service with a withhold, or some combination. Payments may be augmented by a modest pay-for-performance bonus linked to clinical quality, patient experience, adoption of health information technology, practice certification, or other participatory recognition programs.

To varying degrees, organized medical groups may accept shared or full risk for inpatient care. Emerging models include quality- or performance-based contracts that link bonuses or payment levels to quality and/or efficiency thresholds. Other structures include a primary care case management fee paid on a per member per month basis. Some primary care medical home or accountable care contracts also include prospective gain-sharing for achieving total cost of health care targets, or may also include progress payments for milestones such as volume of patients enrolled.

Hospital payment structures are varied, with per diem and case rates more prevalent among commercial plans than Medicare diagnosis-related group (DRG) case rates. The Premier/CMS Pay-for-Performance program, Medicare STARS performance rating program, and the CMS hospital value-based purchasing strategy have accelerated adoption of quality- and outcomes-based contracts *among private plans*, with payments linked to performance, participation in public reporting initiatives, or participation in regional and multistate collaboratives.

Medicare policies have also created significant interest among private payers in nonpayment for health care–acquired conditions and serious reportable events. There are limited efforts to introduce episode contracting, but these have not been widely adopted because of administrative challenges around claims processing and patient identification and qualification. Global budgeting and quantifying potentially avoidable complications have also been tested on a limited basis as a way to promote improvement and establish a shared savings objective between payers and hospitals.

Federal initiatives to provide financial incentives to use health information technology may also carry over into private payments for physicians and hospitals.

The Medicare Shared Savings Program for accountable care organizations has reinvigorated dialogue on managing total risk. Such organizations could enhance regional competition within health insurance exchanges, but patient attribution to a primary care physician remains a key issue in defining the terms of shared risk.

DEVELOPING A FRAMEWORK FOR QUALITY IMPROVEMENT REPORTING REQUIREMENTS

Section 2717 of the Affordable Care Act specifies that health plans shall report on benefit designs and provider reimbursement structures that aim to improve health outcomes, prevent hospital readmissions, improve patient safety, and promote health and wellness activities. Similarly, Section 1311 requires health plans participating in health insurance exchanges to provide information to the exchange and enrollees on the same activities.

A Potential Quality Improvement Framework

In considering a framework to meet these reporting requirements, there are significant opportunities to align health plan quality improvement and measurement efforts across other national initiatives to focus health plan and provider improvement activities. The National Quality Strategy (NQS) pursues the “Triple Aim” of improving population health, improving care experiences, and controlling per capita costs (Exhibit 1). Other relevant examples include elements of the National Prevention Strategy, federal

requirements for providers to make “meaningful use” of electronic medical records, and the measures for accountable care organizations defined in the Medicare Shared Savings Program regulations. Common domains across these initiatives and the NQS priorities reflect a broad view of quality improvement:

- making care safer by reducing harm;
- engaging patients and family as partners in their care;
- promoting effective communication and care coordination;
- promoting the most effective prevention and treatment practices;
- working with communities to enable healthy living; and
- making high-quality care more affordable through new health care delivery models.



National Quality Strategy

The National Quality Strategy articulates a set of six priorities to achieve the “Triple Aim” of improving population health and patients’ care experiences, while controlling costs:

1. Making care safer by reducing harm caused in the delivery of care.
2. Ensuring that each person and family is engaged as partners in their care.
3. Promoting effective communication and coordination of care.
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Working with communities to promote wide use of best practices to enable healthy living.
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

The National Quality Strategy further articulates 10 principles for designing specific initiatives to achieve the Triple Aim. Many of the approaches to addressing the health plan reporting requirements can reinforce these principles:

1. Payment incentives that foster better health, quality improvement, innovation, and greater value.
2. Public reporting initiatives offer consumers and payers vehicles to compare costs, review treatment outcomes, assess patient satisfaction, and hold providers accountable.
3. Public and private collaborative efforts.
4. State and federal regulations create public standards for safe, reliable care, monitor providers, ensure feedback and accountability, and strengthen patient safety and quality improvement.
5. Consumer incentives and value-based insurance.
6. Measurement of care processes and outcomes using consistent, nationally endorsed measures in order to provide information that is timely, actionable, and meaningful to both providers and patients.
7. Adoption of health information technology.
8. Timely and actionable feedback for clinicians and other providers.
9. Training, professional certification, and workforce and capacity development.
10. Innovation and rapid-cycle learning.

As described below, health plans might structure their benefit design and provider reimbursement strategies according to these priority areas. The examples are intended to be illustrative only—aimed at fostering dialogue about health plans’ improvement strategies and potential approaches to assessing their effectiveness.

Making Care Safer by Reducing Harm

The Centers for Disease Control and Prevention estimates that at least 1.7 million health care–associated infections occur each year, leading to 99,000 deaths. Adverse medication events cause more than 770,000 injuries and deaths each year—and the cost of treating patients who are harmed by these events is estimated to be as high as \$5 billion annually. (See National Strategy for Quality Improvement in Health Care, Report to Congress, March 2011, <http://www.healthcare.gov/center/reports/nationalqualitystrategy032011.pdf>.)

Benefit designs targeting patient safety may include incentives to choose higher-performing providers with demonstrated outcomes such as fewer patient complications due to serious reportable events or health care–acquired conditions (HACs).

Reimbursement mechanisms may include performance-based payments, as well as nonpayment for HACs. In addition to reduced complications, measures could include reduced frequency of adverse drug interactions, medical errors, and avoidable readmissions, and their associated costs.

Engaging Patients and Family as Partners in Care

Health care delivery is often organized around specific conditions and focused on whether clinical symptoms are resolved, rather than whether patients achieve their desired outcomes. But engaging patients and their families is critical to improving health outcomes and delivering patient-centered care. To encourage patients to get involved, many health plans offer member education and health coaching services, along with Web-based decision-support tools that can be distinguished by their content, functionality, and if they can be customized to a patient’s circumstances. Increasingly, plans are using motivational interviewing and similar techniques to help patients set goals and improve their self-care skills, as well as consumer segmentation strategies to deliver targeted outreach.

There are few tools with which to measure the effectiveness of such efforts. Most pay-for-performance programs rely on surveys, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS), that assess patient satisfaction, rather than patient activation or self-efficacy. Traditional CAHPS-based measures may not provide comparable results among health plans, unless steps are taken to control for the differences among the plans’ benefit designs and cost-sharing levels. Individuals with

high levels of cost-sharing tend to be less satisfied with their health plans than those with lower out-of-pocket expenses. Because health plans may need to have high levels of cost-sharing to achieve an affordable premium, there is the question of whether exchange plan performance and patient experience should be measured separately from the health plan's overall book of business. Metrics assessing plans' efforts to promote shared decision-making could document patients' understanding of their treatment choices, or assess decision quality that tests patients' knowledge and whether their values and preferences have been taken into account. Measures should also assess whether health plans provide tools to support caregivers.

Health information technology may facilitate the use of patients' reports in outcomes-based performance metrics. For example, clinical registries or electronic health records could make it easier to assess health status and patient-reported outcomes for certain services, such as knee replacement or cardiac surgery, that are sensitive to functional or symptom improvement.

Promoting Effective Communication and Care Coordination

Health plans seek to ensure that their contracted providers coordinate care to reduce gaps and duplication in services. Plan-based care management programs often target chronically ill and high-risk patients, but such efforts often are not linked to providers' own care management programs or hospital-based discharge planning. Benefit design incentives are occasionally used to encourage members to participate in such programs. Health plans may encourage care coordination by promoting medical homes and accountable care organizations. Reimbursement structures for these delivery models vary considerably, with per member per month management fees, payment for enhanced patient access such as through telehealth tools or e-mail, and in some cases, global budgets as an incentive to manage an entire population.

Assessments of health plans' activities in this area have focused on the percentage of members engaged in care management programs, the frequency of outbound and inbound member outreach, and evidence of patient outreach and reminder messages to address gaps in care. In some cases, purchasers maintain performance guarantees to ensure a positive return on investment, or to ensure that select indicators are met such as reductions in ambulatory care-sensitive admissions, emergency department utilization, and avoidable hospital readmissions.

Hospital pay-for-performance programs could take into account care coordination measures such as documentation of an advance care plan in the electronic medical record,

tracking of care gaps, use of a patient self-care plan, and medication reconciliation after hospital discharge. Health plans' care coordination programs might be rated on the turnaround time for a "welcome home" call post-hospital discharge or evidence of a follow-up visit with the patient's primary care physician within a week.

Promoting the Most Effective Prevention and Treatment Practices

The NQS advocates targeting improvement efforts on high-priority conditions such as cardiovascular disease. Health plans offer a wide range of primary and secondary interventions to address high-cost and high-frequency conditions. Benefit design tactics are frequently used to promote preventive care services and manage chronic conditions. Even before cost-sharing elements for preventive services were eliminated in the Affordable Care Act, many benefit designs reduced or waived member out-of-pocket costs for routine preventive and diagnostic screenings. Value-based benefit design strategies have provided an additional impetus to pursue recommended care by reducing or waiving copayments and coinsurance in conjunction with adherence to recommended treatment and achievement of biometric goals. Various public reporting and performance-based payment initiatives also reward providers for improving clinical processes and outcomes.

Working with Communities to Enable Healthy Living

The NQS seeks to increase the use of evidence-based interventions to improve population health. Benefit designs may include incentives to participate in smoking cessation or weight loss programs. Assessment of health plan capabilities may include process metrics such as the number of members' completing health risk appraisals or use of such survey tools to engage at-risk individuals. Importantly, purchasers may also look for evidence of tailored communications to identify familial health risk factors and/or risk factors associated with race or ethnicity. Consideration may also be given to a plan's strategy to address underdiagnosed and undertreated conditions, or to identify and address disparities in care and cultural competency, for example by stratifying clinical quality measures by demographic factors pertinent to health equity.

Making High-Quality Care More Affordable

Affordability is a critical issue in attracting enrollment and sustaining the health plan offerings within the health insurance exchanges. Both health plans and providers should be held responsible for ensuring high-value care. While employers' benefit design strategies may reward higher-value plans by lowering the employee premium contributions, deductibles and point-of-service costs may be increased to lower overall premium to achieve a budget target. In addition to the price of a health plan, a wide range

of factors can indicate how efficiently a health plan delivers its services, ranging from its medical loss ratio and administrative costs to risk-adjusted utilization markers, such as hospital length of stay and emergency room use. Plans may in turn link their provider reimbursement structures to measures of appropriateness and efficiency, as well as transparency to make cost and quality information available to consumers.

In promoting affordability and value, the NQS seeks to establish common measures that will help assess the cost of new programs and payment systems for families, employers, and the public sector, along with how well these programs support innovation and effective care. It also seeks to: integrate measurement of cost and resource use, together with patient experience and outcomes, into the full range of public and private sector efforts to reform payment; reduce waste from undue administrative burdens; and make information about health care costs and quality available to consumers and providers.

Criteria for Selection of Quality Elements

To advance this discussion, the following criteria may be useful to guide the selection of quality improvement reporting requirements for health plans' benefit design and provider reimbursement strategies:

1. conforms to statutory requirements;
2. consistent with National Quality Strategy and other federal programs;
3. likelihood that “measured” activities and/or reporting will contribute to improvement of health outcomes;
4. builds upon existing documentation and reporting systems where possible and limits additional administrative burdens;
5. has face validity to consumers, health plans, providers, and policymakers; and
6. submitted information can be verified.

During the roundtable meeting, some participants expressed the view that measures should not be constrained by the strength of evidence available to document their effect, particularly for new measures designed to fill gaps in existing domains such as member engagement and care transitions. Participants also discussed when it was sufficient to report population-wide outcomes (in cases where outcomes measures are available) and when it would be better to assess the processes and programs that show how a plan achieves those results. Additionally, participants noted that it might be sufficient to report certain measures and processes across an entire commercial

population, while some data should be reported for just the population enrolled in exchanges, who may have unique characteristics because they are a newly insured population and/or because of the benefit designs offered through the exchanges.

Key Considerations for Developing and Aligning Quality Reporting Requirements

This report reviews several approaches the HHS secretary could take into account in developing the quality reporting requirements. The final approach should consider issues such as:

- How can the requirements under Section 2717 be aligned with those under Section 1311 and those under other federal programs, particularly the overarching National Quality Strategy?
- How can the federal reporting requirements be aligned with existing or emerging private sector requirements, such as health plan accreditation and the eValue8 Request for Information?
- How can reporting requirements for quality improvement strategies be closely aligned with health plan performance reporting requirements, both within Section 1311 and elsewhere (as well as with the quality rating system for qualified health plans and the enrollee satisfaction survey)?
- To what extent is the type of information desired by consumers to make choices about their health plans and health care providers the same or different?
- Should the reporting requirements on “plan or coverage benefits and health care provider reimbursement structures” be interpreted broadly to align with emerging measures and measurement frameworks or narrowly based on statute?
- Are the quality reporting requirements clearly defined relative to what a plan may include or exclude as “activities that improve health care quality” under the medical loss ratio regulations? These are defined as activities designed to increase the likelihood of desired health outcomes in ways that can be objectively measured. The activities must be primarily designed to: 1) improve health outcomes; 2) prevent hospital readmissions; 3) improve patient safety; 4) implement, promote, and increase wellness and health activities; and 5) enhance the use of health care data to improve quality, transparency, and outcomes. Insurers are also allowed to include health information technology expenses needed to accomplish activities that improve health care quality.

Potential unintended consequences are another important consideration. For example, a focus on acquiring more information on health disparities, including racial and ethnic disparities, could influence insurers to use this information to avoid subgroups of the population who might be of higher need and/or higher cost. Conversely, explicitly recognizing that minorities and other vulnerable populations often have higher disease burdens could be a path to creating incentives (for both providers and health plan members) that recognize the “heavier lift” required to achieve comparable outcomes for these groups. Such payment incentives could have a significant effect on the market and safety-net providers and could encourage providers and insurers to reach out to these populations, if the incentives were sufficient. Similarly, creating bundled or episode payments with the goal of driving efficiency may create a disincentive for providers to treat high-risk patients, absent some mechanism for severity adjustment.

MEASURING HEALTH PLAN EFFORTS TO IMPROVE QUALITY THROUGH BENEFIT DESIGN AND PROVIDER REIMBURSEMENT STRATEGIES

Today, health plan performance is measured through a growing array of standardized measures assessing preventive care and clinical processes, intermediate outcomes (e.g., blood pressure or cholesterol levels), as well as care experiences and outcomes (e.g., functional status) for some populations. These measures encompass those included in the Healthcare Effectiveness Data and Information Set (HEDIS), developed and maintained by the National Committee for Quality Assurance (NCQA), as well as other measures developed and maintained by entities including the Centers for Medicare and Medicaid Services (CMS). CMS requires many of these performance measures to be reported by health plans participating in Medicare Advantage.

In addition, many of these measures are required by states for reporting associated with Medicaid managed care programs or regulatory requirements promulgated through states’ health departments or insurance commissioners. These performance measures are specified, collected, and calculated in a manner allowing for easy comparison of health plans’ performance. Measures are designed to demonstrate the proportion of an eligible health plan population that received an indicated service or achieved desired outcomes. In addition to HMO/POS health plans, preferred provider organizations also have recently begun to calculate such performance results.

It should be noted that new plan- and provider-level measures are continually reviewed and endorsed through the National Quality Forum and its Measure Applications Partnership. There may also be opportunities to align with new quality measures that are incorporated into the CMS Physician Quality Reporting System and the meaningful use

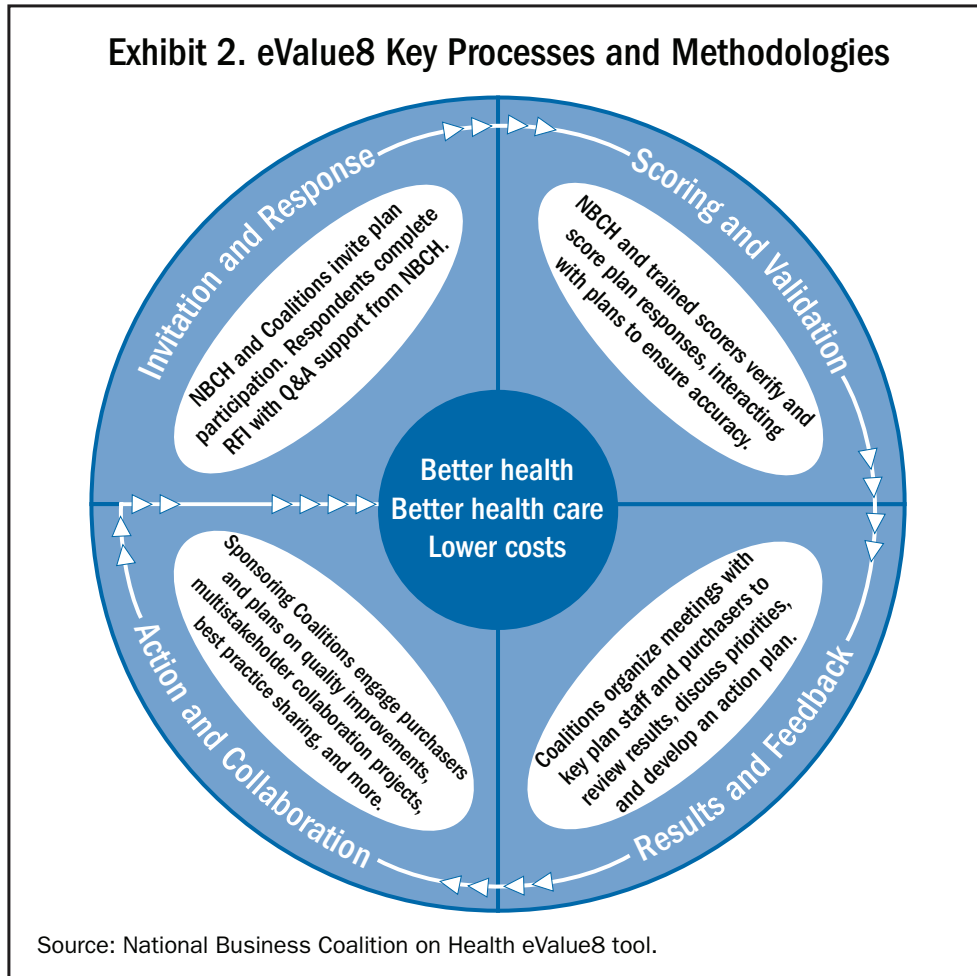
requirements for providers' use of electronic health records. Moreover, performance measurements should consider emerging sources of information through the transition to CPT-II codes for medical claims, more widespread adoption of electronic health records, and proliferation of clinical registries to monitor and improve quality.

Health plans pursue multiple strategies to improve their performance results, including approaches to address population health, care and case management, promotion of evidence-based medicine and guidelines through provider outreach and other means, as well as community and member engagement strategies. Many health plans seek to achieve measureable improvement by rewarding providers for care coordination, care and case management, medication reconciliation and compliance, or acting as a medical home. In addition, health plans may seek to improve value through benefit designs that provide incentives for members to choose evidence-based treatments (e.g., by waiving copayments) or select providers with higher performance ratings. Health plans may also offer decision-support tools to help members make informed choices.

This section focuses on the activities that are currently undertaken to assess or measure health plans' provider reimbursement or benefit design strategies that may favorably affect plans' performance and members' health. We characterize three different and common assessment approaches implemented in the marketplace today: the eValue8 health plan request for information (RFI), health plan accreditation or certification, and Medicaid's external quality review process. [Appendix C](#) provides a more detailed comparison of these approaches.

Developed and maintained by the National Business Coalition on Health (NBCH), eValue8 is an organization of about 60 employer-based health care coalitions representing over 7,000 employers and 25 million individuals. The eValue8 tool is a standard, annual Request for Information (RFI) survey to gather benchmarks in critical areas such as prevention and health promotion, adoption of health information technology, member and provider support, disease management, provider performance measurement and rewards, patient safety, pharmaceutical management, and behavioral health. NBCH's eValue8 strives to work in concert with accrediting bodies, including the National Committee on Quality Assurance, URAC, and the Joint Commission, to prevent redundancy and build on existing standards. In addition to this RFI, health plans may also complete additional RFI instruments to support the procurement decisions of employers who have secured different benefit consultants to aid in the compiling and analyzing of relevant health plan data and information. Exhibit 2, from eValue8's 2010 annual report, illustrates the RFI's driving processes and methodologies.

Exhibit 2. eValue8 Key Processes and Methodologies



Health plan accreditation is commonly offered through the National Committee for Quality Assurance (NCQA) and URAC. For example, NCQA-accredited health plans are reviewed against more than 60 standards and must report on their performance in more than 40 areas in order to earn accreditation. As of 2009, CAHPS and HEDIS results represented 43 percent of the overall accreditation score, with a relatively small subset based on clinical outcomes. Many carriers have also completed the voluntary Physician Hospital Quality module. Additionally, NCQA offers Primary Care Medical Home certification and physician recognition programs that are currently used by many carriers.

NCQA relies on a unified set of standards for HMOs, MCOs, PPOs, and POS plans. NCQA's Review Oversight Committee, a national panel of physicians, analyzes the survey team's findings and assigns an accreditation status based on the plan's compliance with NCQA standards and its performance on selected HEDIS measures, relative to other plans. Exhibit 3 illustrates NCQA's health plan report card, a publicly available consumer information tool available on its Web site.

Exhibit 3. NCQA Health Plan Report Card

For specific areas covered, please contact the plan directly.

Accreditation Details

Accreditation Type:	Health Plan Accreditation
Expiration Date:	10/30/2012
Date of Next Review:	08/07/2012
HEDIS measures included in results:	Yes
CAHPS measures included in results:	Yes

Performance Results

Accreditation Status: Commendable

Accreditation Star Ratings

Access and Service:	★★★★
Qualified Providers:	★★★★☆
Staying Healthy:	★★★★☆
Getting Better:	★★★★☆
Living with Illness:	★★★★☆

This plan has achieved Distinction in the following Quality Plus modules:

- Member Connections
- Care Management and Health Improvement

Source: National Committee for Quality Assurance.

Medicaid managed care’s external quality review (EQR) is another common plan assessment approach. While it focuses on quality measurement and improvement activities, it does not directly report on benefit and provider reimbursement strategies. The Balanced Budget Act of 1997 directed the Department of Health and Human Services to develop protocols for an annual external independent review of the quality outcomes, timeliness of, and access to services provided by Medicaid managed care organizations and prepaid inpatient health plans. This approach follows a different assessment methodology, compared with eValue8 and accreditation. A 2008 Office of the Inspector General report highlighted challenges with variation in reporting and inconsistent completion of deliverables by EQR organizations, as well as inconsistent use of deeming, whereby a state or regulatory agency accepts accreditation in lieu of performing direct audit or oversight functions. A 2009 NCQA Medicaid Managed Care Toolkit identified approximately 75 percent overlap between NCQA standards and federal requirements for quality measurement and improvement, a 67 percent overlap for those related to structure and operations, and a 67 percent overlap for those related to access to care.

While the reporting of results for standardized performance measures is common and routine for most HMO/POS and many PPO plans, detailed assessment and reporting of health plan activities pertaining to their provider reimbursement or benefit design strategies are not. NBCH's eValue8 covers health plans' provider reimbursement and benefit design strategies more thoroughly than other approaches in use today. Both eValue8 and NCQA have developed promising self-assessment methodologies and validation approaches leveraging online tools. These approaches can provide significant guidance for assessment strategies that can support reporting requirements associated with the Affordable Care Act.

USES OF REPORTED INFORMATION FROM HEALTH PLANS

The collection of information about health plans' quality improvement activities should be undertaken with the intended users in mind. Reporting requirements should also address various uses of the information, such as oversight and monitoring, quality improvement, public reporting, and decision support. The audiences for health plan quality information include:

1. state oversight and health insurance exchange boards, as well as governance and operational entities;
2. health plans;
3. consumers;
4. employers; and
5. physicians, hospitals, and provider organizations.

Both qualitative and quantitative information can be collected about the extent to which health plans seek to accelerate and reward quality improvement through provider reimbursement and benefit design strategies. A central question regarding the health insurance exchange reporting requirements is the depth and breadth of the information required to assess the adequacy of their quality improvement strategies and oversee the effectiveness of their implementation. Purchasers have relied on both NCQA accreditation and eValue8 to collect program and service operations data and, to varying degrees, to assess the effectiveness of a plan's programs. Beyond descriptive measures of quality strategies such as how provider performance is measured, purchasers have sought information on the strength and effect of the quality effort, such as total dollars allocated and actually paid based on performance criteria. While these are important indicators, they are not the same as measures of health outcomes.

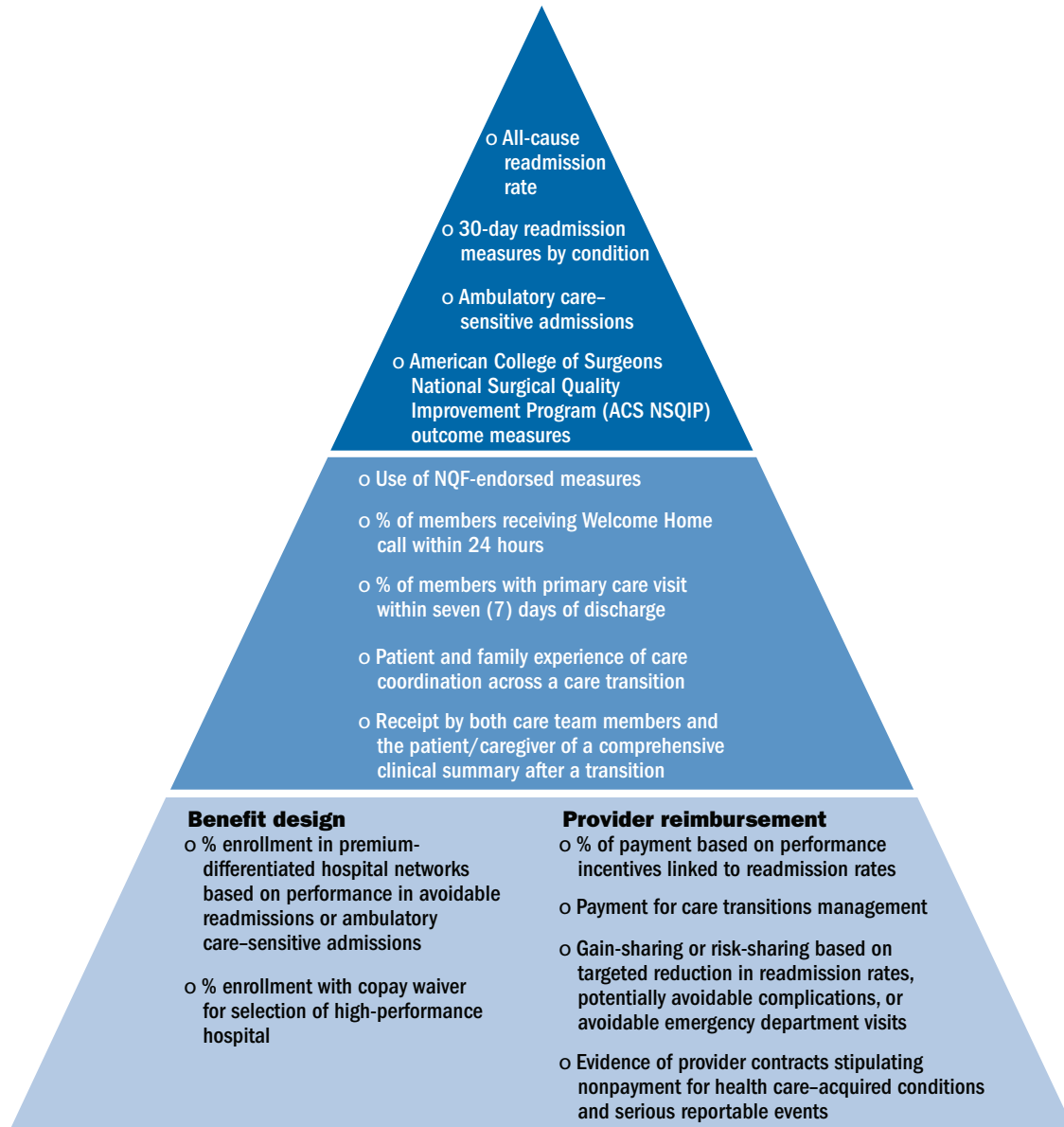
Reporting requirements should consider the availability, credibility, and specificity of outcomes measures, process measures, and operational indicators or survey results where outcomes are not available. For example, if diabetes outcomes measures reflecting effective management of clinical goals are available, there may be less need to know what portion of performance payments is allocated to diabetes measures or the percentage of providers meeting a performance threshold. Similarly, a risk-adjusted hospital ICU mortality rate or all-cause readmission rate may be sufficient to differentiate plan performance, rather than information about the structure of a plan's case management and discharge planning support. However, if the results of such measures are heavily influenced by a Medicare population, they may have less relevance for a privately insured population or an exchange population with uncertain turnover. Absent population-specific outcomes data, it may be relevant to consider indicators with a shorter time horizon for reports from health plans in the exchanges. For example, with respect to care management programs, it may be desirable to obtain exchange-specific data about the risk stratification of enrolled members, targeted members, engagement results, types of interventions, and the effect of those interventions, such as reduced gaps in care or improved medication adherence.

There also may be unintended consequences in the selection of measures and other performance indicators for quality reporting. If the metrics follow the NQS recommendation to target leading causes of mortality such as cardiovascular disease, this should not supplant investments in other preventive care strategies and risk reduction. Provider reimbursement strategies should consider access for underserved populations.

Exhibit 4 uses hospital readmissions, one of the quality improvement categories specified in statute, to illustrate the continuum of process indicators to outcomes measures, supported by varied benefit design and provider reimbursement tactics that could be adopted to enhance quality and improve value. Arguably, the hospital readmission outcomes measures are sufficient, but it may also be important to identify clinical processes and benefit or payment indicators used to effect reductions in readmission rates (e.g., pay-for-performance or gain-sharing contracts). Some of the reporting indicators and process measures may inform best practices, while enhancement of patient experience measures may identify additional opportunities for quality improvement. [Appendix D](#) includes a more detailed description of reportable performance indicators for each measurement domain specified in Section 2717 of the Affordable Care Act.

Exhibit 4. Illustrative Hierarchy of Measures and Reporting Indicators for Hospital Readmissions

■ Outcomes
 ■ Clinical processes and patient experience
 ■ Reporting indicators



The regulations could establish multiyear goals for quality improvement and measure progress toward fulfilling targets. By establishing reporting strategies on effective provider reimbursement strategies, health plans and providers may accelerate adoption of evidence-based approaches to promote value. Notably, the types of clinical measures and program indicators that are relevant for oversight of plans in the health insurance exchanges may be different than information that is useful for purchasers or consumer decision support.

Information reporting should also consider the types of decisions made by consumers about choice of provider, choice of treatment, and potential out-of-pocket costs. While the latter is outside the scope of Section 1311 requirements, there are nevertheless quality indicators that can be correlated with better value, efficiency of care delivery, and reduced waste. The quality rating system should also assess whether plans are making information about the performance of individual physicians and hospital service lines (such as cardiac, orthopedic, or maternity) available to their members; public reporting in both areas is rapidly evolving. Research has shown that physician-level measures are what consumers need and want. Additionally, it is critical to educate those who will use the information on its potential uses for decision-making purposes.

Other information to be reported includes plan features and services such as disease management, health coaching, or wellness programs. Exhibit 5 displays plan information from the University of California Plan Chooser tool.

Exhibit 5. Member Support: Health Plan Services Information Used

The screenshot displays the 'MEDICAL PLAN CHOOSER' interface. It includes a navigation menu with options like '< Return to your profile', 'Costs >', 'Doctors >', 'Quality Ratings >', 'Features >', 'Services >', and 'Results >'. The main content area is titled 'Plan Rules & Features' and provides information on how to rate plans based on their fit with user needs. Below this, there are several comparison tables.

Diabetes Comparison Table:

Plan	Diabetes
Kaiser Permanente CA HMO	Free program includes one-on-one counseling, group counseling and help by phone. Patient education services include self-care and behavior change educational materials online and by mail. Program includes preventive screenings and PCP referral to specialist or case management health professional.
Health Net Blue & Gold HMO	Free program includes phone and email support from health coaches. Online tools to identify risks, self-care steps, track health changes, and treatment options. Other services include audio libraries, streaming videos and educational materials.
Health Net HMO	Free program includes phone and email support from health coaches. Online tools to identify risks, self-care steps, track health changes, and treatment options. Other services include audio libraries, streaming videos and educational materials.
Anthem Blue Cross PPO	Free program includes counseling help by phone, care plan preparation and follow-up, and reminders about getting care. Also, educational materials online and by mail.

Compare Features Table (Left):

Plan	Seeing a Doctor	Wellness Resources	Medical Conditions	How to Save	Rate or Remove
Kaiser Permanente CA HMO		Plan has back care/pain management program. More...			
Health Net Blue & Gold HMO		Plan has stress management program. More...			
Health Net HMO		Plan has nutrition & weight management program. More...			
Anthem Blue Cross PPO		Online personal health record includes email your doctor, get test results and appointment scheduling online. More...			
		Plan has stop smoking program. More...			

Compare Features Table (Right):

Plan	Stop Smoking
Kaiser Permanente CA HMO	Free program includes help quitting through in-person and phone counseling; online, self-directed education program, with individualized smoking cessation plan. Group classes offered. Most classes provided at no charge to members. Over-the-counter aids (nicotine patch, gum). Helpline for referrals to community resources.
Health Net Blue & Gold HMO	StayWell free program includes an online assessment of your needs and ways to change behaviors. Get online education help for how to quit, handling quit day and withdrawal symptoms, nicotine replacement therapy and more. For high-risk members, get help by phone from a wellness coach and additional educational materials.
Health Net HMO	StayWell free program includes an online assessment of your needs and ways to change behaviors. Get online education help for how to quit, handling quit day and withdrawal symptoms, nicotine replacement therapy and more. For high-risk members, get help by phone from a wellness coach and additional educational materials.
Anthem Blue Cross PPO	StayWell free program includes an online assessment of your needs and ways to change behaviors. Get online education help for how to quit, handling quit day and withdrawal symptoms, nicotine replacement therapy and more. For high-risk members, get help by phone from a wellness coach and additional educational materials.

An additional issue is the extent to which information reported on quality improvement activities should be for all health plan members or for certain populations. While the exchange health plans may be similar to plans currently available for individual and small-group markets, consideration should be given to potential differences in population demographics and availability of information. Further, high turnover among these market segments may limit the ability to measure the longitudinal effects of plan services for these populations.

KEY RECOMMENDATIONS

The July 8, 2011, roundtable provided a rich discussion of current approaches to quality improvement reporting and generated some key recommendations for implementing reporting requirements for health plans.

Recommendation 1. Move ahead strategically, balancing parsimony, standardization, and innovation.

In light of the many existing quality-related initiatives and new requirements called for in other portions of the Affordable Care Act, federal implementation of the provisions in Sections 2717 and 1311 should emphasize dimensions of care delivery and payment reform that align with the National Quality Strategy and hold the greatest promise for delivering significant improvement in health outcomes and value. Attention also should be given to fill gaps in the NQS framework, particularly those related to care coordination, patient-reported outcomes, and affordability, including both efficiency and resource use. A forward-looking strategy can also foster new and effective care redesign while leveraging emerging sources for clinical outcomes data.

For any new measures, HHS may want to consider a phase-in of the reporting requirements, allowing for initial experiences to guide fuller implementation. Overly prescriptive reporting requirements could have the unintended consequence of reinforcing current programs and processes geared toward maximizing performance for existing measures, and serve as a disincentive to try new approaches that might achieve better outcomes. Use of standardized outcomes measures can set market expectations, while allowing plans to promote innovative care processes to improve health. There is an opportunity to learn from how employers have been using this type of information and to stimulate market innovation, value gains, quality improvement, and coverage expansion.

Recommendation 2. Focus on health outcomes, where available, and supplement by reporting on improvement strategies only in cases where outcomes reporting is not yet feasible.

Reporting requirements could prioritize outcomes measures, where available, and incorporate process measures and reportable indicators of quality, effectiveness, and reach when they are not. The approach should take into account the evidence base for the improvement strategies as well as the current state of performance measurement in each area. For example, there are adequate outcomes measures for patient safety and hospital readmission, so that reporting on the reimbursement and benefit strategies aimed at these areas may not add much value. For other domains, additional effort is needed to define the areas of “improving outcomes” and “wellness and prevention” delineated in statute. Reporting on the uptake of a given benefit or participation in innovative payment models may be indicative of the appropriateness and effectiveness of that particular plan strategy, though these factors also could be influenced by the characteristics of the plan’s provider network or covered population. At the same time, such reporting may help disseminate best practices and illuminate such issues as risk segmentation.

Recommendation 3. Recognize and address the information needs of diverse users of public reporting on quality improvement strategies.

While the development of consumer reporting and a health plan performance dashboard is not in the scope of this report, it is important to recognize the varied uses of quality reporting and the level of information that is of interest and relevant to various stakeholders. Consumers want easy-to-use, actionable information. While alignment of reporting requirements is desirable, the types of information and detail required for oversight and quality improvement are different than those needed for public reporting and to inform consumers’ decision-making.

Recommendation 4. Support consistent implementation across health plans and exchanges.

In light of the substantial variation in population, provider, and market characteristics across the country, and the likely variation that will occur at the state level in the design and implementation of health insurance exchanges, clear federal guidance and implementation tools for public and private sectors will be critical to ensuring benchmarking capabilities across states. At the same time, promoting standardization across states and the public and private sectors will foster simplicity and consistency in the information available for consumer decision support.

CMS could help smooth implementation and minimize burden by issuing clear guidance and a suite of tools. These tools may include templates, instructions, and reporting formats for state exchanges, employers, plans, and those responsible for developing public reports and Web sites. This federal effort could continue over time, collecting lessons learned and best practices and making them broadly available.

Recommendation 5. Balance value and judicious use of resources in the implementation of reporting.

As demonstrated in this report, there is much knowledge and practical experience to draw on while implementing the reporting requirements. Thus, CMS could adapt existing reporting processes to fulfill the requirements. Given that multiple organizations currently focus on performance measurement and reporting, quality improvement, and accreditation, clear guidance from the federal government would permit these efforts to be adapted to satisfy reporting needs. Reporting enhancements should also focus on areas where there are gaps in measurement, such as consumer engagement and care coordination. Attention should be paid to the needs of the newly insured enrollees in the exchanges, taking into account their health literacy, disparities in care, and the cultural competency of plan and provider services. This guidance and support also should be integrated with other new requirements stemming from the Affordable Care Act.

Recommendation 6. Invest in initial testing and develop a learning infrastructure for evaluation and improvement of reporting over time.

To date, there have been few efforts to report health plans' quality improvement strategies to consumers and others. Initial testing with the intended users of these new reports, including state regulators, employers, and consumers, is warranted. In particular, focus groups that assess how consumers use the information will be important. Consumers' understanding of the disconnect between the costs and quality of care may be more relevant to their decision-making than what they may know about the effect of provider payments on the care they receive (e.g., that the volume of diagnostic procedures might be different if a provider received a bundled payment instead of fee-for-service). However, the latter may be relevant for federal and state oversight of health plans' provider reimbursement strategies aimed at improving health outcomes and ensuring affordability.

As reporting requirements are implemented, it will be important to monitor whether there are any unintended consequences and consider implications for future policy considerations. It also will be important to align public and private value-based

purchasing initiatives to facilitate knowledge transfer and accelerate adoption of best practices.

Recommendation 7. Provide criteria to guide periodic review and updates to the quality reporting requirements.

The quality reporting requirements need to include a process for regular review and updates to reflect new evidence and innovation that delivers improved outcomes or better value. Broader adoption of electronic health records and health information exchange will likely enhance the ability to report health outcomes that can replace multiple clinical process measures. However, new or refreshed quality reporting that accelerates innovation, better care, and better value must be balanced with its ability to be expanded and replicated in various market settings.

Appendix A. Participants at Roundtable Discussion

On July 8, 2011, The Commonwealth Fund sponsored a meeting of experts, stakeholders, and government officials to discuss issues and options for quality improvement reporting by qualified health plans under the Affordable Care Act, specifically addressing Sections 2717 and 1311. This report provides an overview of several existing approaches to quality reporting and provides a set of recommendations informed by the discussion at the meeting. Participants in the meeting included:

Alexis Ahlstrom, M.P.H., Center for Consumer Information and Insurance Oversight
Tanya Alteras, M.P.P., Consumer-Purchaser Disclosure Project/National Partnership for Women and Families
Richard Baron, M.D., Seamless Care Models Group, Center for Medicare and Medicaid Innovation
Andrew Baskin, M.D., Aetna
Anne Beal, M.D., M.P.H., Patient-Centered Outcomes Research Institute (formerly Aetna Foundation)
Robert Berenson, M.D., The Urban Institute
Carmella Bocchino, R.N., M.B.A., America's Health Insurance Plans
Amy Boutwell, M.D., M.P.P., STAAR Initiative/Harvard Medical School
Marshall Chin, M.D., University of Chicago Medical Center
Jon Christianson, Ph.D., University of Minnesota School of Public Health
Carolyn Clancy, M.D., Agency for Healthcare Research and Quality
Helen Darling, M.A., National Business Group on Health
Joyce Dubow, Ph.D., AARP Office of Policy and Strategy
A. Mark Fendrick, M.D., University of Michigan School of Public Health
Steven D. Findlay, M.P.H., Consumers Union
Anne Gauthier, M.S., National Academy for State Health Policy
Robert Greene, M.D., UnitedHealthcare
Aparna Higgins, America's Health Insurance Plans
Emma Hoo, Pacific Business Group on Health
George Isham, M.D., HealthPartners
Marcia Guida James, M.S., M.B.A., Humana, Inc.
Craig Jones, M.D., Vermont Blueprint for Health
Minyoung (Min) Kim, M.P.H., Beacon Communities/Office of the National Coordinator for Health Information Technology
David Lansky, Ph.D., Pacific Business Group on Health
Tricia Leddy, M.S., Rhode Island Department of Health
Cara Lesser, M.P.P., Office of Health Insurance Exchanges, Center for Consumer Information and Insurance Oversight
Jerry Lindrew, J.D., M.S., Employee Benefits Security Administration, Department of Labor
William B. Munier, M.D., Center for Quality Improvement and Patient Safety, Agency for Healthcare Research and Quality
Margaret O'Kane, M.H.S., National Committee for Quality Assurance
L. Gregory Pawlson M.D., M.P.H., F.A.C.P., Blue Cross Blue Shield Association

Kerri Petrin, The Brookings Institution
Chris Queram, M.A., President and Chief Executive Officer, Wisconsin Collaborative for
Healthcare Quality
Barbra Rabson, M.P.H., Massachusetts Health Quality Partners
Joachim Roski, Ph.D., M.P.H., Booz Allen Hamilton (formerly Engelberg Center for Health Care
Reform, The Brookings Institution)
Dana Gelb Safran, Sc.D., Blue Cross Blue Shield of Massachusetts
Richard Salmon, M.D., Ph.D., CIGNA HealthCare
Joshua Seidman, Ph.D., Office of the National Coordinator for Health Information Technology
Joel Slackman, M.S., Blue Cross Blue Shield Association
Paul Wallace, M.D., Center for Comparative Effectiveness Research, The Lewin Group
Rebecca Zimmermann, Office of Health Insurance Exchanges, Center for Consumer Information
and Insurance Oversight



Sara Collins, Ph.D., vice president, Affordable Health Insurance, The Commonwealth Fund
Karen Davis, Ph.D., president, The Commonwealth Fund
Stu Guterman, Ph.D., vice president, Payment and System Reform; executive director,
Commission on a High Performance Health System, The Commonwealth Fund
Rachel Nuzum, M.P.H., assistant vice president, Federal and State Health Policy,
The Commonwealth Fund
Cathy Schoen, M.S., senior vice president, Policy, Research and Evaluation,
The Commonwealth Fund
Anthony Shih, M.D., M.P.H., vice president for programs, The Commonwealth Fund
Gerry Fairbrother, Ph.D., senior fellow, AcademyHealth
Hilary Kennedy, M.P.A., M.Sc., senior associate, AcademyHealth
Enrique Martinez-Vidal, M.P.P., vice president, AcademyHealth
Lisa Simpson, M.B., B.Ch., M.P.H., F.A.A.P., president and chief executive officer, AcademyHealth

Appendix B. Section 2717 and 1311 of the Affordable Care Act

Section 2717: Ensuring the Quality of Care.

(a) QUALITY REPORTING. –

(1) IN GENERAL. – Not later than 2 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary, in consultation with experts in health care quality and stakeholders, shall develop reporting requirements for use by a group health plan, and a health insurance issuer offering group or individual health insurance coverage, with respect to plan or coverage benefits and health care provider reimbursement structures that –

(A) improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model as defined for purposes of section 3602 of the Patient Protection and Affordable Care Act, for treatment or services under the plan or coverage;

(B) implement 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;

(C) implement 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; and

(D) implement wellness and health promotion activities.

(2) REPORTING REQUIREMENTS. –

(A) IN GENERAL. – A group health plan and a health insurance issuer offering group or individual health insurance coverage shall annually submit to the Secretary, and to enrollees under the plan or coverage, a report on whether the benefits under the plan or coverage satisfy the elements described in subparagraphs (A) through (D) of paragraph (1).

(B) TIMING OF REPORTS. – A report under subparagraph (A) shall be made available to an enrollee under the plan or coverage during each open enrollment period.

(C) AVAILABILITY OF REPORTS. – The Secretary shall make reports submitted under subparagraph (A) available to the public through an Internet website.

(D) PENALTIES. – In developing the reporting requirements under paragraph (1), the Secretary may develop and impose appropriate penalties for non-compliance with such requirements.

(E) EXCEPTIONS. – In developing the reporting requirements under paragraph (1), the Secretary may provide for exceptions to such requirements for group

health plans and health insurance issuers that substantially meet the goals of this section.

(2) LIMITATION ON DATA COLLECTION.-None of the authorities provided to the Secretary under the Patient Protection and Affordable Care Act or an amendment made by that Act shall be construed to authorize or may be used for the collection of any information relating to –

- (A) the lawful ownership or possession of a firearm or ammunition;
- (B) the lawful use of a firearm or ammunition; or
- (C) the lawful storage of a firearm or ammunition.

(3) LIMITATION ON DATABASES OR DATA BANKS. – None of the authorities provided to the Secretary under the Patient Protection and Affordable Care Act or an amendment made by that Act shall be construed to authorize or may be used to maintain records of individual ownership or possession of a firearm or ammunition.

(4) LIMITATION ON DETERMINATION OF PREMIUM RATES OR ELIGIBILITY FOR HEALTH INSURANCE. – A premium rate may not be increased, health insurance coverage may not be denied, and a discount, rebate, or reward offered for participation in a wellness program may not be reduced or withheld under any health benefit plan issued pursuant to or in accordance with the Patient Protection and Affordable Care Act or an amendment made by that Act on the basis of, or on reliance upon –

- (A) the lawful ownership or possession of a firearm or ammunition; or
- (B) the lawful use or storage of a firearm or ammunition.

(5) LIMITATION ON DATA COLLECTION REQUIREMENTS FOR INDIVIDUALS. – No individual shall be required to disclose any information under any data collection activity authorized under the Patient Protection and Affordable Care Act or an amendment made by that Act relating to –

- (A) the lawful ownership or possession of a firearm or ammunition; or
- (B) the lawful use, possession, or storage of a firearm or ammunition.

(d) REGULATIONS. – Not later than 2 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall promulgate regulations that provide criteria for determining whether a reimbursement structure is described in subsection (a).

(e) STUDY AND REPORT. – Not later than 180 days after the date on which regulations are promulgated under subsection (c), the Government Accountability Office shall review such regulations and conduct a study and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report regarding the impact the activities under this section have had on the quality and cost of health care.

Section 1311: Affordable Choices of Health Benefit Plans.

(g) REWARDING QUALITY THROUGH MARKET-BASED INCENTIVES. –

(1) STRATEGY DESCRIBED. – A strategy described in this paragraph is a payment structure that provides increased reimbursement or other incentives for –

(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;

(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; and

(E) As added by section 10104(g). the implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.

(2) GUIDELINES. – The Secretary, in consultation with experts in health care quality and stakeholders, shall develop guidelines concerning the matters described in paragraph (1).

(3) REQUIREMENTS. – The guidelines developed under paragraph (2) shall require the periodic reporting to the applicable Exchange of the activities that a qualified health plan has conducted to implement a strategy described in paragraph (1).

Appendix C. Comparison of Existing Health Plan Quality Improvement Reporting Tools

Assessment Area	eValue8 Health Plan Request for Information	NCQA Health Plan Accreditation	Medicaid Managed Care Monitoring (EQR)
<p>What aspects about health plans' benefit design and provider payment strategies are assessed? What content or concepts are assessed?</p>	<ul style="list-style-type: none"> • Administrative functions and services, including accreditation and value-based benefit design, • Consumer engagement, as measured by price and performance transparency, decision-support tools, and CAHPS results, • Provider measurement and rewards, including community collaboration and network differentiation • Pharmaceutical management, • Health promotion and prevention, including smoking cessation, maternity care • Chronic disease management, • Behavioral health, • Clinical areas supported by HEDIS data. 	<ul style="list-style-type: none"> • Quality management and improvement, • Utilization management, • Provider credentialing, • Members' rights and responsibilities, • Member engagement (member connections), • Results of HEDIS/CAHPS Performance Measures, • Medicaid benefits and services. • Optional NCQA's Physician and Hospital Quality certification program evaluates how well health plans measure and report the quality and cost of physicians and hospitals. • Health plans' benefit design programs or provider reimbursement strategies are not directly assessed. 	<p>The External Quality Review assesses how state Medicaid agencies develop and implement a mandated quality assessment and improvement strategy that includes:</p> <ul style="list-style-type: none"> • standards for access to care; structure and operations; and quality measurement and improvement; • examination of other aspects of care and services related to improving quality; and • regular and periodic review of the improvement strategy. <p>Compliance review includes:</p> <ul style="list-style-type: none"> • Enrollee rights and protections, • Quality assessment and performance improvement, • Grievance systems, • Fraud and abuse, • Administrative systems, • Provider networks and management, and • Data management. <p>EQR has the option of reporting on validation of encounter data, validation of consumer and provider surveys on quality of care, calculation of additional performance measures, and conduct of additional performance improvement and quality projects.</p>

Assessment Area	eValue8 Health Plan Request for Information	NCQA Health Plan Accreditation	Medicaid Managed Care Monitoring (EQR)
<p>What evidence or criteria are used to select content areas and concepts for assessment?</p>	<ul style="list-style-type: none"> Evidence is directly referenced in the annual Request for Information tool. Use of nationally standardized measures endorsed by the National Quality Forum Multiple assessment areas represent new and innovative policy areas for which systematic evidence may not be currently available. 	<ul style="list-style-type: none"> Research evidence is used to develop and maintain HEDIS measures. Survey questions are field-tested prior to use and inclusion as optional CAHPS supplemental items Quality standards seek to reflect health plan best practices. 	<ul style="list-style-type: none"> EQR does not select content but validates performance improvement projects undertaken by an MCO/PIHP. How a plan conducted its specific improvement initiatives (indicators monitored, population selection, and data collected and analyzed) Measure the achieved results and ability for the MCO's performance improvement project to sustain any achieved improvements.
<p>Who is involved in the determination of selecting content areas for selection?</p>	<ul style="list-style-type: none"> Business coalition staff, Employer advisory councils, Health plan advisory council, Experts and policymakers from the CDC, AHRQ, the American Board of Internal Medicine and other organizations, Academic researchers, Draft tool are made available to health plans, employers, and others for comment and refinement prior to release, Collaborators include accreditation agencies and consumer and purchaser organizations such as Leapfrog Group, Consumer-Purchaser Disclosure Project, and Catalyst for Payment Reform. 	<ul style="list-style-type: none"> Multiple ad hoc committees with subject matter experts and stakeholder representation, Standards Committee, Committee on Performance Measures, and Board of Directors. 	<ul style="list-style-type: none"> Subject to regulatory requirements.
<p>How is information collected and disseminated?</p>	<ul style="list-style-type: none"> Online survey with free-form questions, tables with embedded options, and data fields. Information is uploaded by health plans to the tool and transmitted to the requesting entity (e.g., a business coalition or employer). 	<ul style="list-style-type: none"> Interactive Survey System (ISS), a Web-based tool. Health plans complete a self-assessment document as to how they meet all published standards. Detailed scoring is reported to the plan HEDIS and CAHPS results are reported online through Quality Compass (subscription required for detailed reporting) 	<ul style="list-style-type: none"> Data collection vehicle varies. Information release varies by state.

Assessment Area	eValue8 Health Plan Request for Information	NCQA Health Plan Accreditation	Medicaid Managed Care Monitoring (EQR)
How is the content assessed?	<ul style="list-style-type: none"> Scoring algorithm is updated regularly to weigh content/assessment areas relative to their perceived differential contribution to value, health improvement, or member utility (e.g., health outcomes results weighted more heavily than process indicators; user-customizable and interactive Web content weighted more than static data). When available, research evidence is used for weighting of concepts; often expert judgment is relied on to determine specific weights. Typically, values are scored on an absolute and not relative scale. Some elements collected as information only. Percentage performance results are reported for each module. 	<ul style="list-style-type: none"> Onsite and offsite evaluations conducted by a survey team of physicians and managed care experts. Points assigned to each standard. Typically standards are not assessed in a binary fashion (met/not met); most standards are assessed gradually (e.g., met fully, met 80%, met 50%, etc.). Points across different standards areas are combined with the results of performance report submitted by health plans to determine a five-level accreditation status (excellent, commendable, accredited, provisional, denied). 	<ul style="list-style-type: none"> Onsite and offsite evaluations conducted by EQRO staff. EQRO may benchmark performance to national and statewide Medicaid results, or may review year-over-year trends for individual MCOs. Compliance is assessed relative to federal Medicaid managed care regulations.
How is information verified as comprehensive and accurate?	<ul style="list-style-type: none"> Corroborating descriptive information is required to support specific answers, such as copies of health plan documents detailing certain aspects (e.g., screenshots of online consumer engagement tools). Coalition staff and consultants analyze the submitted information with respect to congruence. 	<ul style="list-style-type: none"> Pre-specified, specific electronically transmitted documents corroborating the self-assessment of specific standards, such as meeting minutes and program policies. NCQA staff ensures the relevance of submitted information. 	
How many health plans currently submit information under this assessment approach?	<ul style="list-style-type: none"> Between 30-50 national and regional health plans provide responses. Volume fluctuates depending on employers' procurement strategies and regional coalition sponsorship. 	<ul style="list-style-type: none"> NCQA-accredited health plans represent 71 percent of the enrolled population. 500 health plan products are included in NCQA's QualityCompass, a benchmarking tool containing time-trended performance results for participating health plans. 	<ul style="list-style-type: none"> Medicaid managed care organizations. Prepaid inpatient health plans.

Assessment Area	eValue8 Health Plan Request for Information	NCQA Health Plan Accreditation	Medicaid Managed Care Monitoring (EQR)
Resource requirements	<ul style="list-style-type: none"> • Compilation of data, responses, and written narrative from subject matter experts. • Documentation of specific areas required for verification. • HEDIS and CAHPS data are auto-populated from NCQA Quality Compass reports. • Annual rotation of select modules, auto-population of regional responses based on national results and optional use of a “short-form” mitigate some resource investment. • Organizational resources required to submit and analyze the requested data vary significantly between health plans and the requesting entities. • Web-based response. 	<ul style="list-style-type: none"> • Compilation of all relevant documentation, performance measure results, • Preparation for on-site visits, • Full accreditation review is generally only required every three years, but a portion of the score is recalculated every year based on HEDIS performance. • Data aggregation, including chart review for select measures, and analysis for HEDIS reporting. • CAHPS sampling, follow-up, and analysis. • Web-based tool available. 	<ul style="list-style-type: none"> • States may perform EQR tasks directly or subcontract to EQR organization(s). • EQRO aggregates the information on all required activities, analyzes data, and produces a technical report and recommendations.
Use of the collected information	<ul style="list-style-type: none"> • Information about health plan program features and relevant benchmarks are used by purchasers for procurement decisions and vendor management. • Several business coalitions including the Pacific Business Group on Health incorporate information collected through eValue8 into an online health plan chooser tool aimed at consumers/employees. • Other organizations such as Minnesota’s Buyers’ Healthcare Action Group or Pitney Bowes may publish online reports aimed at consumers to aid health plan selection during the annual enrollment process. • Some plans use detailed Strength and Opportunity report for quality and process improvement initiatives • Other plans use purchaser feedback to prioritize new initiatives and program development. 	<ul style="list-style-type: none"> • Accreditation and HEDIS performance results are used by health plans to improve internal processes and provider performance, and by employers and brokers/consultants to evaluate procurement decisions and manage suppliers. • State agencies and regional collaboratives publish accreditation and HEDIS performance results for consumer information • Federal and state agencies may require all or parts of the NCQA accreditation and performance measurement efforts to meet regulatory or purchasing requirements. 	<ul style="list-style-type: none"> • States use results from EQR assessment to direct how plans document and conduct performance improvement projects and how plans meet federal and state standards regarding members’ access to care. • States use EQRO reports to target technical assistance to the plans with identified deficits and sharing best practices across plans. • States amend plan contracts and set new performance standards based on EQRO reports.

Notes: NCQA is the National Committee for Quality Assurance; CAHPS is the Consumer Assessment of Healthcare Providers and Systems; HEDIS is the Healthcare Effectiveness Data and Information Set; MCO is managed care organization; CDC is the Centers for Disease Control and Prevention; and AHRQ is the Agency for Healthcare Research and Quality.

Appendix D. Reportable Indicators of Quality Improvement Strategies, Measures, and Program Operations

The table below illustrates a sample of the wide range of benefit design and provider reimbursement tactics that could be adopted to enhance quality and improve value. Within strategies to improve quality, there may be various approaches to measure their impact, as well as their scope and depth with respect to health plans participating in the exchanges. For example, with respect to health and care management programs, it may be desirable to obtain exchange-specific data about the risk stratification of enrolled members, targeted members, engagement results, types of interventions, and effect of those interventions, such as reduced gaps in care, improved medication adherence or possession rates, and other factors.

Reporting Domains	Benefit Design	Provider Reimbursement
Health Outcomes <ul style="list-style-type: none"> • Quality reporting • Effective case management • Care coordination • Chronic disease management • Medication and care compliance initiatives 	<ul style="list-style-type: none"> • Premium-differentiated provider networks based on quality performance with reported enrollment, percentage of providers meeting criteria and quality/cost results • Inclusion of performance information or designation programs in provider directories • Incentives for participation in care management programs • Value-based benefit designs to incent engagement in treatment option decision support, adherence to recommended preventive and diagnostic services, adherence to maintenance medications • Patient experience & CAHPS-type survey • Transparency of cost and quality information for consumers • Evidence of patient engagement metrics such as Patient Activation Measure (PAM) 	<ul style="list-style-type: none"> • Physician pay for performance based on clinical outcomes, HEDIS results, CAHPS results, evidence of reduced gaps in care or improved adherence to evidence-based guidelines • Facility pay for performance based on clinical outcomes, quality, CAHPS results, or mortality rates (severity-adjusted) • Percentage of payments (bonus, fee-for-service, etc.) linked to performance • Support and payment for accountable care structures or primary care medical home services
Hospital Readmissions	<ul style="list-style-type: none"> • Premium-differentiated hospital networks based on performance in avoidable readmissions or ambulatory care-sensitive admissions • Percentage of members receiving welcome home calls upon hospital discharge • Percentage of members who have follow-up primary care appointment within 7 days 	<ul style="list-style-type: none"> • Payment for care transitions management • Gainsharing or risk-sharing based on targeted reduction in readmission rates, potentially avoidable complications, or avoidable emergency department visits • Evidence of provider contracts stipulating non-payment for preventable hospital readmissions

Reporting Domains	Benefit Design	Provider Reimbursement
Patient Safety and Medical Errors	<ul style="list-style-type: none"> • Premium-differentiated provider networks based on patient safety management • Use of reference pricing in conjunction with quality indicators to encourage selection of higher-performing providers or use of Centers of Excellence • Coverage for medication reconciliation review, with polypharmacy management and frequency of drug–drug conflicts identified 	<ul style="list-style-type: none"> • Differentiated payment based on Health IT adoption (e-prescribing, computerized physician order entry, HITECH Meaningful Use requirements) • Frequency and disposition of health care–acquired conditions (HACs) and serious reportable events (SREs) • Evidence of provider contract requirements for root cause analysis of medical errors • Demonstration of evidence-based practices (e.g., pre-39 week C-sections or elective inductions)
Wellness and Health Promotion Activities	<ul style="list-style-type: none"> • Value-based benefit designs to incent engagement in treatment option decision support, adherence to recommended preventive and diagnostic services, adherence to maintenance medications, as measured by reduced gaps in care and medication possession rates, respectively • Availability and use of incentives for health risk reduction • Availability and use of incentives for completing Health Risk Appraisal and related screening tools • Incentives to use consumer tools and complete consumer education, treatment decision support, and self-care sessions • Percentage of members engaged in condition management programs or health risk reduction programs • Evidence of patient reminder programs using various media and response tracking 	<ul style="list-style-type: none"> • Preventive HEDIS measures • Percentage of providers using standard PHQ-9 depression screening tool with validation through sample chart audit • Percentage of members for whom smoking status and BMI are captured • Evidence of tailored communications to identify familial health risk factors and/or risk factors associated with race or ethnicity
Health and Health Care Disparities	<ul style="list-style-type: none"> • Evidence of targeted risk identification based on familial risk factors • Evidence of tailored member communication strategies • Inclusion of self-reported race/ethnicity information in member registration processes or surveys • Caregiver support 	<ul style="list-style-type: none"> • Percentage of members for whom race/ethnicity information is captured • Strategies to improve provider cultural competency • Reporting and payment for reduced gaps in care • Language translation support