Vermont Health Benefits Exchange Planning and Implementation Project

Preliminary Analysis of Affordable Care Act Laws and Regulations Relating to Exchange Quality and Wellness Activities

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Purpose

This report provides Vermont with a preliminary analysis of federal law, regulations, and other guidance related to Health Insurance Exchange quality and wellness requirements and activities. As stated in the University of Massachusetts Medical School (UMass) Technical Proposal submitted to the State of Vermont, the goal of the work performed under this contact is to:

> develop a robust quality program for the Vermont Health Exchange that will meet the PPACA requirements for QHPs and will focus quality measurement and reporting on the goals identified in Act 48, including to contain costs, to promote health, prevention, and healthy lifestyles by individuals, and to improve the quality of health care.

At present, the federal government has issued only some of the rules and regulations around Exchange quality activities. Accordingly, this report should be considered preliminary. Upon release by the federal government of additional rulemakings related to Exchanges and quality, we will prepare an expanded and updated version of this report for the State.

Methodology

The data sources for this report include

- Patient Protection and Affordable Care Act (ACA)[1]
- Federal rulemaking
  - 45 CFR Parts 155, 156, and 157: Final rule on Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers.[2]
- Federal guidance
  - State Exchange Implementation Questions and Answers – November 29, 2011
- Vermont Act 48 - An act relating to a universal and unified health system.[3]

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[1] Patient Protection and Affordable Care Act of 2010, Public Law No. 111 – 148, 124 STAT. 119 (2010). http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf

[2] Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 45 CFR Parts 155, 156, and 157, Federal Register vol 77, no. 59, March 27, 2012. http://federalregister.regstoday.com/data/2012/018/FR2012-018444.pdf

[3] An act relating to a universal and unified health system, Vermont State Acts, Act 48 of 2011. http://www.leg.state.vt.us/docs/2012/Acts/ACT048.pdf

- Vermont Rule H-2009-03 (Department of Banking, Insurance, Securities and Health Care Administration, now called Department of Financial Regulation) – Consumer Protection and Quality Requirements for Managed Care Organizations. Referred to as Rule 9-03.[4]

We reviewed each document for information related to requirements for Health Insurance Exchanges related to quality and wellness as well as other quality and wellness provisions that may impact Exchange operations. *Appendix One* provides a side-by-side comparison of the ACA and Act 48 provisions related to quality and wellness.

Key Findings - Quality

Section 1311 of the Patient Protection and Affordable Care Act outlines the requirements for Health Insurance Exchanges. *Appendix Two* provides the text of the applicable ACA sections.

The US Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) have clearly signaled their intention to have quality and wellness as key goals of the ACA. Activities in both areas are not only desirable ends in themselves; they are the cornerstone of efforts to control the costs of health care in the future ("bending the cost curve" downward).

We have grouped the Section 1311 quality and wellness requirements into four categories:

1. Certification of Qualified Health Plans (QHPs) to be offered through Exchange
   – Sections 1311(c)(1)(D)&(E)&(H)&(I)

2. Reporting QHP quality and wellness to consumers to aid plan selection
   – Sections 1311(c)(1)(H), 1311(c)(3)&(4)

3. Ongoing monitoring and incenting of QHP performance
   – Sections 1311(c)(1)(I), 1311(g)(1)(A)&(B)&(C) and 1311(g)(1)(E)

4. Wellness and prevention
   – Section 1311(g)(1)(D)

Discussion of each of these roles follows, and includes references to the federal rulemaking and guidance published to date. We also identify decision points for Vermont. In addition, we relate the ACA requirements to Vermont's Act 48. We particularly note substantive areas where Act 48 requirements go beyond those in the ACA.

[4] Consumer Protection and Quality Requirements for Managed Care Organizations, Vermont Department of Banking, Securities, and Health Care Administration, Rule H-2009-03. http://www.dfr.vermont.gov/sites/default/files/REG-H-09-03.pdf

1. QHP Certification – Quality and Wellness

Two facts have been made clear in the federal regulations and guidance released so far: only Qualified Health Plans (QHPs) may be offered on an Exchange, and the Exchange has the sole authority to issue certification that an issuer's product is a Qualified Health Plan. In practice, this means the Exchange has wide discretion to determine what requirements must be met to receive QHP certification. The regulations establish *minimum* quality and wellness standards, but State Exchanges are free to add more stringent requirements. Table 1 (next page) summarizes the requirements presented in the ACA and the Final Rule, and identifies where federal rule-making has already occurred (as indicated by references to CFR – Code of Federal Regulations).

1.1 Accreditation

The ACA requires each qualified health plan to be accredited "with respect to local performance on clinical quality measures."[5] ("Local" would mean statewide in Vermont, since health insurers must offer their products throughout the state.) While the regulations outline the general areas accreditation must cover, the details are largely left to the States.

Act 48 requirements on accreditation (at §1806(c)(1)) refer back to ACA Section 1311. There are no additional Vermont-specific criteria for accreditation mentioned in Act 48. Rule 9-03 does not require accreditation, but it allows for deeming against Rule 9-03 Triennial Review requirements if a plan is accredited.[6]

Table 1: Minimum federal requirements for Qualified Health Plan (QHP) certification: Quality and Wellness

1. Accreditation (*ACA Section 1311(c)(1)(D)(i) and (ii) and later 45 CFR Part 156.275*)
2. Implement and report on quality improvement strategies (*ACA Sections 1311(c)(1)(E)&(g)(1)) and later 45 CFR Part 156.200(b)(5).*
3. Report quality information to enrollees and prospective enrollees (*ACA Section 1311(c)(1)(H)&(I) and later 45 CFR Part 156.200(b)(5))*
4. Sec. 1311(h) directs plans to contract only with hospitals that utilize a patient safety evaluation system and implements a comprehensive discharge (effective in 2015)

As a starting point, HHS has stated that it will recognize accrediting entities, but this will come in future rulemaking. The specific language in the Final Rule discussing this issue suggests that establishing a list of recognized accreditations is a low priority: "We will be issuing future rulemaking to establish a process by which accrediting entities will be recognized."[7] Despite this uncertainty, it seems reasonable to expect that the most prominent national accrediting

[5] ACA Section 1311(c)(1)(D)(i); PPACA (Consolidated) text p. 71.

[6] Vermont Rule H-2009-03, part 6.8 (A), p. 75.

[7] 45 CFR 155-157 (preamble section), Fed. Reg., March 27, 2012, p. 18429.

organizations (such as NCQA and URAC) will be on the list that emerges. In fact, NCQA staff verbally confirmed this expectation during an online seminar presented by Academy Health on April 9, 2012, stating that they expect NCQA to be confirmed by HHS as an accreditor.[8]

The Exchange also determines the timeline for QHP accreditation, and how this relates to the Exchange's certification timeline. For example, an Exchange may grant QHP certification prior to the issuer's obtaining accreditation. There is no federally-set deadline after receipt of certification by which certified plans must receive accreditation. This is left to the Exchange's discretion. (Conversely, an Exchange is free to require accreditation as a condition of certification.)

> *Decision Point for Vermont: Should accreditation be required as a condition for initial QHP certification?*

During the UMass team's recent meeting with the Vermont Exchange workgroup, the Vermont group stated that they expect two issuers to participate in the Exchange: Blue Cross/Blue Shield of Vermont and MVP Health Care. According to the NCQA website, commercial plans in Vermont for both of these issuers are already NCQA-certified.[9] If the Vermont Exchange implemented a timeline requiring accreditation as a precondition of certification, it could do so in the knowledge that the expected participants would meet the requirement. Moreover, the NCQA/HEDIS data from these plans could fulfill the data quality reporting requirements that go into effect when the Exchanges "go live" on January 1, 2014. Rule 9-03 also requires annual submission of HEDIS, CAHPS, and a number of Vermont-specific measures (including access to providers, number of grievances, timeliness of grievance resolution, utilization review decision timeliness, and provider satisfaction), regardless of whether the plan is accredited.[10]

The exchange should bear in mind, however, that requiring NCQA (or other entity) accreditation up front could deter other issuers from entering the Vermont Exchange. To avoid this risk, Vermont should consider a phased approach to implementing the accreditation requirement. Applicants not currently accredited would be given up to 18 months to become accredited. These applicants would be required to submit an attestation to Vermont that they had applied for accreditation with an approved HHS accrediting entity.

The first quality-related task that the Vermont Exchange must perform is to have in place approximately one year before opening, a plan for QHP *certification* requirements with respect

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[8] Audio portion of Academy Health's "How State Exchanges Can Implement Health Plan Quality Reporting" webcast, April 9, 2012. Audio file not currently available online. Web address to be added here when available.

[9] http://reportcard.ncqa.org/plan/external/PlanList.aspx?name=&state=VT&zipcode=-1&plantype=1,2&statename=Vermont. Accessed 3/20/12.

[10] Vermont Rule H-2009-03, part 6.6 (B), pp. 73-74. This section does not specifically name HEDIS and CAHPS as sources of standardized (non-Vermont specific) measures, but the context makes clear that these are the expected sources.

to *accreditation* (by an HHS-recognized entity).[11] This plan must include a timeline relating accreditation to certification. In other words, the Exchange must decide whether a health plan issuer must have accreditation before receiving certification as a QHP from the Exchange. If the Exchange decides to allow issuers to be certified without accreditation, the Exchange should create a post-certification deadline by which the issuer must receive the accreditation. We recommend a July 1, 2014 deadline to allow 18 months for the accreditation process.

1.2 Quality Improvement Strategies, including Wellness

The ACA is quite specific about the preferred areas for quality improvement: health outcomes, preventing hospital readmissions, improving patient safety and reducing medication errors, implementing wellness and health promotion activities, and reducing disparities. QHPs are responsible for implementing quality improvement strategies as described in ACA Section 1311(g)(1), while the Exchange is tasked with evaluating these strategies in 45 CFR Part 155.200(d).[12] However, specific guidance in this area is still pending. The final rule restates the earlier proposed rule's language that HHS "intend(s) to address the content and manner of quality reporting under this section in future rulemaking."[13]

Two specific provisions found in both Act 48 and Rule 9-03 go beyond the ACA requirements. First, both Act 48 and Rule 9-03 require plans to engage in "joint quality improvement activities" with other plans.[14] In fact, joint QI activities are already underway as part of Rule 9-03. This emphasis on joint quality improvement by plans is a significant innovation that clearly fits with the longer-term goal of an integrated, universal health system under Green Mountain Care. Second, both Act 48 and Rule 9-03 stipulate that plans must actively participate in the Blueprint for Health, Vermont's state-led delivery system transformation program. Opportunities for coordinating plan-level quality improvement, wellness, and health promotion programs with the Blueprint goals will be discussed in a future deliverable.

The Vermont Exchange is well-placed to meet the ACA requirements for quality improvement strategies. Accreditation by both NCQA and URAC require health plans to undertake quality improvement projects, so the leading insurers in the Vermont market will already have projects underway. In addition, plans are currently complying with the extensive quality improvement requirements contained in Rule 9-03. These requirements include submission of QI work plans and project reports (including joint projects) on an annual basis.

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[11] Per call with CMS. March 17, 2012

[12] Please note that the paragraph referencing quality improvement has been renumbered. In the Final Rule it is 155.200(d), while in the proposed rule it was 155.200(f).

[13] 45 CFR 155-157 (preamble section), Fed. Reg., March 27, 2012, p. 18325.

[14] Act 48, Section 1806(c)(2).; Vermont Rule H-2009-03, part 6.3 (D), pp. 65-66.

Decision Point for Vermont: What should the Exchange require from applicants to demonstrate compliance with the Quality Improvement standard?

For prospective issuers that already have accreditation, the Exchange could require submission of the applicable portion of the most recent accreditation survey. Projects discussed in this portion should relate to one or more of the areas identified in the ACA and listed above. If the issuer does not currently have a quality improvement project in one of the required areas, Vermont could request evidence that such a project is planned.

For issuers that are in the process of pursuing accreditation, an attestation that a QIP in one of the topic areas is being planned could be required.

1.3 Reporting on Quality Measures

The ACA requires issuers seeking certification to provide information to enrollees and the Exchange on required federal quality measures. Although these measures have yet to be specified, it is likely they will include metrics from the CHIPRA core set and the new CMS Medicaid adult core set.[15]

While Act 48 has no additional provisions relating to quality measure reporting, Rule 9-03 does have extensive annual reporting requirements (discussed above in Section 1.1).

The Exchange itself is not responsible for collecting the data to construct the quality measures; rather, the Exchange requests the QHPs to report the results to the Exchange. The Exchange will certify as QHPs those issuers who are able to report the required measures, once they are specified by HHS. We expect that data from already available sources, such as accreditation surveys (especially HEDIS data that plans report to NCQA), will satisfy the minimum ACA requirements, when they are codified.

Decision Point for Vermont: Should the Exchange require quality reporting that goes beyond the expected minimum as a requirement for certification?

As discussed previously, the ACA requirements set only a floor, not a ceiling, so the State is free to add more stringent requirements for QHP certification. Such additional requirements may be added at any time (i.e., as part of the initial certification process leading up to the Exchange "go-live" date of January 1, 2014, or later, as part of re-certification.) Since Rule 9-03 already requires reporting beyond the ACA minimum, the Exchange could incorporate these additional requirements.

While at this point, we have no specific recommendations for additional quality measures, we would emphasize that this area represents an opportunity for the Vermont Exchange to press its vision of quality as the State moves toward a unified system under Act 48. As a general

[15] ACA Section 1311(c)(1)(H) and (I).

recommendation, we suggest using the current Rule 9-03 annual data filings as a menu from which to select additional measures.

1.4 Patient Safety

Beginning in 2015, health plans seeking certification through an Exchange must contract only with hospitals (more than 50 beds) that have a demonstrated patient safety evaluation system and also have a comprehensive hospital discharge program. Additionally, QHPs may only contract with health care providers who implement quality improvement mechanisms as specified through HHS regulation.

Act 48 has no additional requirements relating to patient safety. The Vermont Department of Health operates the Patient Safety Surveillance and Improvement System (PSSIS), which works at hospital (facility) level to monitor adverse events and support quality improvements that enhance safety.[16] However, this program does not specifically monitor health plans.

Vermont should be able to determine if all hospitals with more than 50 beds are in compliance with the ACA provisions on patient safety evaluation and discharge planning. If data are not already available through the State's hospital regulatory agency, the Department of Health, then Exchange staff should conduct a survey of all hospitals with over 50 beds to assess compliance. If any hospitals are found not to be in compliance, the State should inform such hospitals of the ACA requirements, and work with the hospitals to bring them into compliance.

Decision Point for Vermont: None.

2. Quality and Wellness Information for Plan Selection

Exchange web sites must provide consumers and employers with two types of quality information: quality relative to other plans (quality ratings) and enrollee satisfaction survey results.[17] The goal of presenting this information is to allow consumers to easily compare the QHPs available through the Exchange. Neither the ACA nor the Final Rule gives details on the actual content of the quality rating system and satisfaction survey. These will be the subject of future rulemaking.

Act 48 adds significant dimensions to the core ACA requirements on quality reporting. First, Act 48 directs Vermont's Exchange to assign a "quality *and wellness*" [emphasis added] rating to QHPs, following the future HHS rulemaking. The language used in the ACA and the Final Rule refers only to quality, not wellness, in respect to the ratings system.

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[16] A description of the PSSIS program is available at http://healthvermont.gov/hc/patientsafety.aspx (accessed 5/29/12).

[17] ACA Section 1311(d)(4)(C), later 45 CFR Part 155.205(b).

Second, Act 48 directs the Exchange to provide "consumers *and health care professionals* with satisfaction surveys and other mechanisms for evaluating" QHPs [emphasis added].[18] The ACA language on satisfaction surveys has no reference to "health care professionals." A survey of provider satisfaction with insurers has been developed and implemented under Rule 9-03. Survey questions developed under Rule 9-03 will help meet the Act 48 requirement.

The critical issue with respect to quality reporting seems to be timing. In the recent Question and Answer document, CMS advised Exchanges that they will not need to collect any new quality data, nor will be required to produce "a QHP-specific rating," until 2016.[19] This suggests the expected future rulemaking giving details of the quality rating system may not be available for some time. The statement further implies that any quality information on Exchange websites when they go live in 2014 will instead come from data sources already in use by the states.

> *Decision Points for Vermont: 1) Should the Exchange integrate wellness into its reporting requirements for QHPs? If so, when should it be required, and from what data sources would it come? 2) Should the Exchange start reporting quality, patient satisfaction and other information earlier than 2016?*

Given the emphasis on preserving State flexibility in the ACA, we would expect Vermont to be free to add wellness criteria as part of the comparative plan information on the Exchange website. While the quality rating system at the QHP level will apparently not be required in 2014, the Exchange could collect and include information on each QHP's wellness programs as part of the web site's section on summary of plan benefits and coverage. Rule 9-03 Triennial Reviews have obtained information on wellness and health promotion programs in the past, and may serve as a first source of data. Once HHS releases its rule on the quality ratings system, we again expect the State to have the option of incorporating wellness criteria.

Collecting data on wellness will likely require going beyond the initial quality measures specified by HHS in their future rulemaking, but Vermont should be well placed in to exceed the minimum ACA requirements, by leveraging existing data such as that from the Rule 9-03 Triennial Reviews. In addition, NCQA has a Wellness and Health Promotion Accreditation product.[20] The Exchange could require QHPs to obtain this accreditation as a condition of certification, either in 2014 or later.

Vermont may wish to move ahead of ACA requirements for reporting to consumers. For example, the annual plan performance and quality measures collected under Rule 9-03 and are

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[18] Act 48, Section 1805(13).

[19] "State Exchange Implementation Questions and Answers," p. 8.

[20] For information, see http://www.ncqa.org/tabid/834/Default.aspx.

formatted for consumers already, so they could be distributed immediately once the Exchange begins operation.

3. Ongoing Monitoring of QHP Performance

Monitoring of QHPs after their initial certification will be a core responsibility of the Exchange, but as with other aspects of the ACA, the details await future rulemaking. In addition, there is considerable substantive overlap between initial QHP certification and ongoing monitoring. This section will focus on areas not covered above.

The ACA describes three core responsibilities for Exchanges related to plan monitoring:

- Oversight of the enrollee satisfaction survey for each health plan that has more than 500 enrollees (discussed in section 2 above),
- Monitoring of complaints and appeals, and review of health plan data, including disenrollment and the number of denied claims,[21] and
- Evaluation of QHP quality improvement strategies (discussed in section 1.2 above) and providing incentives based on the results of these strategies.[22]

3.1 Monitoring Plan Quality and Enrollee Satisfaction

Just as the initial QHP certification process will require substantial data collection, ongoing monitoring requires that the Exchange establish processes for regular data updates, and for new data as needed. In addition to the health care quality measures discussed in section 1.3 above, the Exchange will need to collect data from QHPs on administrative measures that affect member access to care, such as disenrollment and denial of claims.

As discussed previously, the law and regulations only clearly establish that the Exchange has the authority and responsibility to monitor QHPs, but the details are left for future rulemaking. It appears that the primary mechanism for monitoring after the initial certification is through the Exchange's power to recertify, and if necessary decertify, a QHP. While it is the Exchange's responsibility to establish processes for both recertification and decertification, only a few details have been codified at this point. Among these are:

- In any given calendar year, the recertification process must be completed by September 15 (though this does not imply that recertification must occur annually).[23]

[21] ACA Sections 1311(c)(1)(D) and 1311(e)(3)(A).

[22] ACA Sections 1311(g).

[23] 45 CFR 155-157, Fed. Reg., March 27, 2012, section 155.1075, p. 18468.

- The Exchange may decertify a QHP at any time, if the Exchange determines that a QHP no longer meets the certification criteria. The Exchange must create a process for QHPs to appeal decertification, and must provide a special enrollment period to enrollees of decertified QHPs.[24]

Act 48 basically restates the ACA criteria for certification (initial and ongoing), with the specific addition of wellness, which is not mentioned in the ACA language.[25] (See section 1.2 above, and section 4 below, for additional discussion of wellness.)

Rule 9-03 already requires annual data reporting on the quality domains specified by the ACA. These include care quality, member and provider satisfaction, and review of utilization management activities.

> *Decision Points for Vermont: 1) How often should the Exchange require data updates on satisfaction surveys and plan quality and administrative measures? 2) How often should the Exchange require QHP recertification? 3) Should the Exchange set up a decertification process that reviews data more frequently than the recertification process?*

As with other policy areas, the ACA and accompanying regulations give the State wide latitude in setting up requirements for regular QHP data submission and performance monitoring. Future rulemaking is forthcoming, but it seems likely that the rule will follow the general pattern of setting a minimal floor only, leaving Vermont free to put more stringent rules in place. The annual data filings under Rule 9-03 could also serve as Exchange data updates, meaning that the Exchange could require annual updates without creating additional administrative burden (Decision Point 1, above). Similarly, the existing Triennial Review process under Rule 9-03 could be adopted as the recertification process for QHPs under the exchange (Decision Point 2, above). While recertification might take place only every three years, a decertification process could be initiated at any point if results from annual data reporting suggest serious deficiencies.

3.2 Incentives for Quality Improvement

The regulatory uncertainty extends to the use of market-based incentives to improve health outcomes, improve quality, implement health and wellness promotion programs, and reduce health disparities.[26] The regulations to date have given no guidance to States; future rulemaking will provide details. For the purposes of Exchange planning, the market-based incentives

[24] 45 CFR 155-157 (preamble section), Fed. Reg., March 27, 2012, section 155.1080, p. 18468

[25] Act 48, Section 1806(a) and (c).

[26] ACA Section 1311(g).

described in the original ACA text would apparently work at the QHP level (through reimbursement policies).[27]

Act 48 expands on the ACA's incentive language in two ways. First, ACT 48 links payer-side incentives to the additional goals of increasing consumer satisfaction and controlling cost growth.[28] These two topics are not mentioned in the ACA section on incentives (Section 1311(g)). Act 48 also mentions incentives to enrollees "providing incentives to residents to avoid preventable health conditions, promote health, and avoid unnecessary emergency room visits," but this is in the context of the Green Mountain Care Board's duties, rather than the Exchange.[29]

Rule 9-03 provides authority for and guidance to health plans on incentives to providers, tied to quality improvement activities. Specific areas mentioned in Rule 9-03 include integration of treatment for behavioral health and medical conditions and improved management of chronic conditions.[30]

> *Decision Points for Vermont: 1) Should the Exchange begin planning for an incentive program directed at QHPs in advance of the expected HHS rulemaking, or wait for rules to be issued? 2) Should the Exchange work with the Green Mountain Care Board in developing rules around individual (enrollee) incentives?*

Again, the flexible regulatory environment surrounding the ACA leaves room for Vermont to be proactive in creating incentive programs at both the QHP and enrollee levels. Future project deliverables will discuss these topics in detail.

4. Wellness and Prevention

The ACA includes multiple references to wellness and prevention. The legislation calls for new councils, programs, and grants related to wellness. It requires all health plans and health plan issuers (whether through the Exchanges or not) to provide, at a minimum, coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women.[31]

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[27] Financial incentives that health plans provide to their subscribers (such as lowered premiums or other rewards for certain behaviors) are subject to rules designed to protect against discrimination based on individual health status. These rules will be discussed in the project deliverables on health plan level Wellness programs. Rule 9-03 also has some limits on these types of financial incentives.

[28] Act 48, amending 18 V.S.A. §9377 (p. 33 of Act 48 text). This language is repeated verbatim elsewhere in the Act.

[29] Act 48, §1821(1).

[30] Vermont Rule H-2009-03, part 6.4 (C), p. 68, and part 6.5 (K), pp. 71-72.

[31] ACA Section 1001, amending the Public Health Service Act Section 2713.

However, the ACA does not *mandate* Exchanges to consider wellness programs as part of certification, except insofar as an applicant has conducted a quality improvement project related to wellness. Nor does the ACA require Exchanges to report wellness information, although states are certainly free to do so.

Act 48 does bring in wellness programs as a requirement, and includes wellness as a key part of the overall QHP quality rating (discussed above in section 2). Act 48 also expands the role of wellness by explicitly making it part of the QHP certification criteria.[32] Additionally, Act 48 contains a provision allowing, but not mandating, the Exchange to offer wellness programs to insurers outside the exchange, and directly to employers.[33] Future UMASS project deliverables will discuss and evaluate wellness programs and interventions in detail.

> *Decision Points for Vermont: 1) What specific wellness-related requirements should the Exchange include in its initial QHP certification process? 2) What wellness elements should the Exchange incorporate in its quality and wellness rating? 3) Should the Exchange prepare to offer stand-alone wellness programs to the broader community, or leave this to the Vermont Department of Health?*

While the ACA does not mention wellness as a QHP certification criterion, Act 48 requires it. Therefore, the Exchange should develop appropriate wellness criteria for both the initial certification process and for ongoing monitoring. The stringency of such requirements is at the Exchange's discretion. These requirements can then form the basis of the wellness component of the Exchange's "quality and wellness rating," which should begin to be developed once HHS releases rules on the rating system.

The third decision point above is really a longer-term, strategic question for the State. The vision presented in Act 48 is for the Exchange to serve as the platform for Vermont's single-payer system. Clearly, given the strong emphasis on wellness and prevention in Act 48, the single-payer system that emerges will have a strong, independent role in wellness. Act 48, however, leaves some ambiguity as to which agency should take the lead in developing statewide wellness programs. While the Exchange is given the option of establishing such programs, Act 48 also directs the Vermont Department of Health to create a state health improvement plan (SHIP), focused largely on wellness initiatives.[34] The VDH has begun work on a SHIP; therefore it may be most efficient for the Exchange to follow the VDH's lead on development of a statewide wellness program.

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[32] Act 48, Section 1806(a).

[33] Act 48, Section 1803(c)(2).

[34] Act 48, Section 26, amending 18 V.S.A. § 5(6).

Discussion/Policy Implications

The critical point that our analysis of the laws and regulations derived from PPACA is that States have great flexibility with respect to the role of quality measurement in Exchange planning and design. The rules only set out the minimum requirements. They do not set any limits on Exchanges that wish to pursue more ambitious quality goals with respect to accreditation, certification, and ongoing monitoring.

As discussed previously, future rulemakings will provide details on the quality rating system and enrollee satisfaction surveys, which will serve as key tools for consumer-directed quality information. Guidance on evaluation of QHP quality improvement and incentive strategies is also forthcoming. The key policy question for the Vermont Exchange, therefore, is whether to concentrate only on operational (non-quality related) aspects of the Exchange until detailed guidance comes out, or to instead make health care quality central to the Exchange's mission without awaiting Federal rulemakings.

Given the emphasis on State flexibility in the regulations published so far, Vermont should feel confident that ambitious quality-related policies built into the Exchange and already present in the state's health care regulatory programs will not run afoul of the rules, as they are eventually codified. The role of quality measurement in the Exchange, as implemented by Vermont, will surely exceed the floor set by the law and regulations.

Summary

In this final section, we restate the decision points identified above.

1. QHP Certification – Quality and Wellness

1.1 Accreditation

Should accreditation be required as a condition for initial QHP certification?

1.2 Quality Improvement Strategies, including Wellness

What should the Exchange require from applicants to demonstrate compliance with the Quality Improvement standard?

1.3 Reporting on Quality Measures

Should the Exchange require quality reporting that goes beyond the expected minimum as a requirement for certification?

1.4 Patient Safety

Decision Point for Vermont: None.

2. Quality and Wellness Information for Plan Selection

1) Should the Exchange require integrate wellness into its reporting requirements for QHPs? If so, when should it be required, and from what data sources would it come?

2) Should the Exchange start reporting quality information prior to 2016?

3. Ongoing Monitoring of QHP Performance

3.1 Monitoring Plan Quality and Enrollee Satisfaction

1) How often should the Exchange require data updates on satisfaction surveys and plan administrative measures?

2) How often should the Exchange require QHP recertification?

3) Should the Exchange set up a decertification process that reviews data more frequently than the recertification process?

3.2 Incentives for Quality Improvement

1) Should the Exchange begin planning for an incentive program directed at QHPs in advance of the expected HHS rulemaking, or wait for rules to be issued?

2) Should the Exchange work with the Green Mountain Care Board in developing rules around individual (enrollee) incentives?

4. Wellness and Prevention

1) What specific wellness-related requirements should the Exchange include in its initial QHP certification process?

2) What wellness elements should the Exchange incorporate in its quality and wellness rating?

3) Should the Exchange prepare to offer stand-alone wellness programs to the broader community, or leave this to the Vermont Department of Health?

Appendix One: Comparative Grid of Key Provisions in ACA and Act 48 Relating to Quality and Wellness

	ACA	Act 48
<u>Exchange Domain:</u>		
Certification	Establish process for certification, recertification, and decertification of QHPs, based on accreditation and other criteria (Sec 1311(d)(4)(A)). Certification criteria defined in Sec 1311(c), and discussed below.	Establish process for certification, recertification, and decertification of QHPs (Act 48 § 1805(1)(A)), based on: Certification criteria as described in ACA Sec 1311 (§ 1806(c)(1)) *and* Coverage level – Silver or above only (§ 1806(b)(2)); "Best interest" determination for certification - Commissioner (DVHA) to consider "promotion of high-quality care, prevention, and wellness" (§ 1806(a)); Additional quality and wellness standards as detailed in future rulemaking by "secretary of human services" *(Almost certain this is VT, not HHS, but need to verify)* (§ 1806(c)(2)); Plan participation in Blueprint for Health (§ 1806(c)(3)); "Any more restrictive requirements provided by 8 VSA chapter 107", the VT health insurance statutes (§ 1806(c)(1)).
Accreditation	Ensure QHPs are accredited with respect to local performance on quality measures, within timeframe established by Exchange (Sec. 1311(c)(1)(D)).	Ensure QHPs are accredited as provided in Sec 1311 of ACA (§ 1806(c)(1)). No VT-specific additional criteria.

	ACA	Act 48
Exchange Domain:		
Quality Improvement Projects	QHPs must implement and report on quality improvement strategy (defined in Sec. 1311(g)), subject to future guidance from HHS.	QHPs must implement and report on quality improvement strategy as defined in ACA Sec 1311 (§ 1806(c)(1)) *and* QHPs must have "joint quality improvement activities with other plans" as directed by secretary of human services *(VT/HHS?)* (§ 1806(c)(2)); Other QI projects/activities through Blueprint for Health (§ 1806(c)(3)).
Reporting Quality Information	QHPs must submit information on health plan performance measures endorsed under Sec.399JJ of PHSA (as amended in ACA Sec 3015) – measures TBD. QHP requirement at ACA Sec 1311(c)(1)(H); QHPs must report pediatric quality measures (CHIPRA core set) at least annually (Sec 1311(c)(1)(I)	QHPs must submit information on health plan performance (measures TBD under ACA/PHSA Sec 399JJ); QHPs must report pediatric quality measures at least annually. No VT-specific provisions.
Quality Rating and Satisfaction Survey	Exchange must assign ratings to each QHP (Sec 1311(d)(4)(D)), using system developed by HHS in future rulemaking (Sec 1311(c)(3)). Exchange must collect enrollee satisfaction survey data (TBD by HHS in future) (Sec 1311(c)(4)). Above items must be on Exchange website.	Exchange must assign a quality *and wellness* rating to each QHP (§ 1805(5)) in accordance with future HHS rulemaking. Exchange must provide consumers *and health care professionals* with satisfaction surveys and other mechanisms for evaluating QHP performance (§ 1805(13)). Above items to be published on Exchange website (§ 1809(b)).

	ACA	Act 48
Exchange Domain:		
Wellness	Not required – included in list of priority quality improvement topics (defined in Sec. 1311(g)).	Wellness is woven into many parts of Act 48, including certification and quality ratings domains (see above); Exchange has option to offer wellness services to insurers outside the exchange, employers, and others (§ 1803(c)(2)).
Patient Safety	Starting 01/01/2015, QHPs can contract only with hospitals that utilize a patient safety evaluation system and implement a comprehensive hospital discharge program, and with providers who implement quality improvement mechanisms TBD by HHS (Sec 1311(h)(1).	No VT-specific provisions.

Appendix Two

ACA Requirements for Health Insurance Exchanges, Section 1311

ACA Section	Text
1311(c)(1)	IN GENERAL.—The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum—
1311(c)(1)(D)(i) and (ii)	(i) be **accredited** with respect to local performance on **clinical quality measures** such as the - Healthcare Effectiveness Data and Information Set - Patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems survey - Consumer access - Utilization management - Quality assurance - Provider credentialing - Complaints and appeals - Network adequacy and access, and patient information programs by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans (so long as any such entity has transparent and rigorous methodological and scoring criteria); or (ii) receive such accreditation within a period established by an Exchange for such accreditation that is applicable to all qualified health plans;
1311(c)(1)(E)	Implement a **quality improvement strategy** described in subsection (g)(1);
1311(c)(1)(H)	Provide **information to enrollees** and prospective enrollees, and to each Exchange in which the plan is offered, on **any quality measures for health plan performance endorsed under section 399JJ of the Public Health Service Act**, as applicable;
1311(c)(1)(I)	Report to the Secretary at least annually and in such manner as the Secretary shall require**, pediatric quality reporting** measures consistent with the pediatric quality reporting measures established under section 1139A of the Social Security Act.
1311(c)(3)	The Secretary shall **develop a rating system** that would rate qualified health plans offered through an Exchange **in each benefits level on the basis of the relative quality and price**. The Exchange shall include the quality rating in the information provided to i**ndividuals and employers** through the Internet portal established under paragraph (4).
1311(c)(4)	The Secretary shall **develop an enrollee satisfaction survey system** that would evaluate the level of enrollee satisfaction with qualified health plans offered through an Exchange, for each such qualified health plan that had more than 500 enrollees in the previous year. The Exchange shall include enrollee satisfaction information in the **information provided to individuals and employers** through the Internet portal established under paragraph (5) in a manner that allows individuals to easily compare enrollee satisfaction levels between comparable plans.
1311(g)(1)	This paragraph [*describes*] a payment structure that provides i**ncreased**

ACA Section	Text
	reimbursement or **other incentive**s for—
1311(g)(1)(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 • use of the medical home model for treatment or services under the plan or coverage;
1311(g)(1)(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 • post discharge reinforcement by an appropriate health care professional;
1311(g)(1)(C)	The implementation of activities to improve **patient safet**y and reduce medical errors through the appropriate use of best clinical practices evidence based medicine health information technology under the plan or coverage;
1311(g)(1)(D)	The implementation of **wellness and health promotion** activities; and
1311(g)(1)(E)	The implementation of activities to **reduce health and health care disparities**, including through the use of • language services • community outreach • cultural competency trainings.
1311(h)(1)	Beginning on January 1, 2015, a qualified health plan may contract with—
1311(h)(1)(A)	A **hospital** with greater than 50 beds only if such hospital— (i) utilizes a patient safety evaluation system as described in part C of title IX of the Public Health Service Act; and (ii) implements a mechanism to ensure that each patient receives 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; or
1311(h)(1)(B)	A **health care provider** only if such provider implements such mechanisms to improve health care quality as the Secretary may by regulation require.


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