

## **Exchanges Plan Management Function: Accreditation and Quality White Paper**

### **1. Introduction**

The federal Patient Protection and Affordable Care Act (ACA) provides for the establishment of American Health Benefit Exchanges (Exchanges).<sup>1</sup> An Exchange must offer only qualified health plans (QHPs) certified by the Exchange to qualified individuals and qualified employers. To participate in an Exchange, QHPs are required to meet accreditation standards and must implement a quality improvement strategy. The ACA addresses the obligations of the Secretary of the U.S. Department of Health and Human Services (HHS), the Exchange, the state, the issuer and the QHP itself.

As part of a national quality strategy, Exchanges will have a significant role in: 1) ensuring that QHPs become accredited and implement quality improvement strategies; 2) providing plan ratings based on quality and cost; and 3) providing patient satisfaction data. The purposes of these requirements are to improve the quality of health care, ensure that QHPs are focused on promoting quality improvement, and improve transparency so that consumers can compare plans based on quality as well as price.

This paper is intended to be a resource to help the states understand the obligations of the Exchange with regard to accreditation and quality. The paper also addresses situations where the states have options, including situations where options may exist but federal guidance on specifics is not yet available.

### **2. Summary of Federal Requirements**

The ACA quality and accreditation requirements are excerpted at the end of this paper for easy reference. Federal law obligates the Exchange to be responsible for certain quality and accreditation elements. The Exchange must evaluate quality improvement strategies and oversee implementation of enrollee satisfaction surveys, assessment and ratings of health care quality and outcomes. The Exchange website must provide standardized comparative information on each QHP, including quality ratings and results of enrollee surveys.

QHP issuers must be accredited by an accrediting entity that meets HHS standards and reflects a variety of quality parameters, such as clinical quality, access and satisfaction, among others. A QHP issuer must receive such accreditation within a time period established by an Exchange, if not already accredited. A QHP issuer must adopt a quality improvement strategy that incorporates increased reimbursement or other incentives for improved health outcomes, prevention of hospital readmissions, improved patient safety, reduced medical errors, wellness and reduced healthcare disparities. An accredited QHP issuer is required to authorize its accrediting entity to share information with HHS and the Exchange. An accredited QHP issuer must maintain its accreditation for as long as it offers QHPs on the Exchange.

### **3. Accreditation Requirements**

#### **a. Requirement to Oversee Assessment of Health Care Quality and Outcomes**

An Exchange must oversee assessment of health care quality and health outcomes. This requirement is at least in part fulfilled by ensuring that QHPs are accredited. Accreditation is an obligation of the QHP issuer.<sup>2</sup> If the QHP issuer does not become accredited within the specific time frame or the QHP issuer does not remain accredited, the QHP will not be certified. An issuer that is not accredited by a recognized accrediting entity on the basis of local performance of its QHP will not be certified to sell coverage through the Exchanges. Exchanges are obligated to oversee this assessment of health care quality and outcomes.<sup>3</sup>

The ACA does not name a specific accrediting entity, but requires that the accreditation must be awarded by an organization that is formally recognized by HHS. There are currently two nationally recognized organizations, the National Committee for Quality Assurance (NCQA) and URAC, which have evolved over the past 20 years for the express purpose of accrediting health plans.<sup>4</sup> The Accreditation Association for Ambulatory Health Care (AAAHC) is another organization that has focused

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<sup>1</sup> Pub. L. 111-148, as amended by Pub. L. 111-152.

<sup>2</sup> ACA, Section 1311(c)(1)(D)(i).

<sup>3</sup> 45 CFR §155.200(d). “The Exchange must...oversee implementation of...”assessment and ratings of health care quality and outcomes in accordance with sections 1311(c)(1), 1311(c)(3), and 1311(c)(4) of the Affordable Care Act.”

<sup>4</sup> For more information about the history and activity of each of these organizations, visit [www.ncqa.org](http://www.ncqa.org) and [www.urac.org](http://www.urac.org).

Adopted by the NAIC Health Insurance and Managed Care (B) Committee on June 27, 2012  
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primarily on accrediting ambulatory care facilities, but also has more than 30 years of experience with accrediting health plans and is recognized by U.S. Centers for Medicare & Medicaid Services (CMS) as a deemed accrediting organization for Medicare Advantage plans.<sup>5</sup> As of the drafting date of this paper, other accrediting entities have not been recognized by HHS or made themselves known to state insurance regulators.

On June 5, 2012, HHS published a proposed rule on recognition of entities for the accreditation of QHPs.<sup>6</sup> This paper references information from the proposed rule in order to provide the most current regulatory guidance. However, the states should be aware that the final rules may include substantial changes from the proposed regulations. On May 16, 2012, HHS issued guidance on federally facilitated Exchanges. State insurance regulators should also be aware that HHS has welcomed comments on this guidance and intends to issue subsequent guidance with additional policy and operational details.

In the proposed rule, HHS announced a two-step process for recognizing accrediting entities. In phase one, HHS proposes to recognize NCQA and URAC on an interim basis, subject to certain conditions.<sup>7</sup> In phase two, HHS intends to establish an application procedure, standards for recognition, a criteria-based review of applications, public participation, and public notice of the recognition for entities seeking to become a recognized accrediting entity.<sup>8</sup> If an accrediting entity is not included in the final regulation on recognition of accrediting entities, it is anticipated that they would need to go through the federal recognition process described in the phase two process.

The states may wish to consider whether there is a role for state recognition of accrediting organizations. Although HHS intends that, for purposes of certification as a QHP, accreditation must be made by an HHS-recognized entity. However, it is unclear whether there could also be some type of role for state recognition. Allowing federal and state recognition under uniform federal standards may be a desirable way to balance the goals of ensuring that all accrediting entities meet the same standards, while also allowing state flexibility to recognize accrediting entities that may be state-specific or otherwise better suited to state, rather than national, recognition. This could potentially serve the goal of giving issuers more choices in accrediting entities and preserve the role of the states in selecting accrediting entities.

The ACA does not preclude the possibility of the recognition of organizations other than NCQA and URAC, including AAAHC, state-recognized entities or state-specific organizations to fulfill the accreditation purposes. It appears possible that a state could have a unique state-specific accreditation body that could seek HHS or state recognition.

In order to earn accreditation from an HHS recognized accrediting entity, a QHP issuer is evaluated in a review that includes quality improvement activities, credentialing of providers, network adequacy standards, utilization management practices, providing information to consumers, enrollee satisfaction surveys, and assessment and ratings of health care quality and outcomes. Accrediting entities typically evaluate health plans in an initial application process, an ongoing oversight process, and a recertification process.

In overseeing this process, State-Based Exchanges (SBEs) could consider adopting a similar approach as HHS in allowing a choice of qualified accreditation entities, including those designated now and in the future by CMS. Such an approach would allow QHP issuers flexibility to choose an accreditation entity that best meets their needs and could reduce costs for issuers because there would be competition between accreditors. Numerous states now recognize multiple accreditors through their health and insurance department regulations. Alternatively, the states may want to consider whether it would be permissible for the states to choose one accreditation program, as a number of the states do for their Medicaid programs. If permissible, this could allow for consistency in evaluation, quality measure collection and approach to scoring plans. It should be noted, however, that the states are able to require uniform measure sets, even if multiple accrediting bodies are operating in a state. Additionally, there are objections that limiting a QHP's choice of accreditors would be costly to issuers, particularly for those that would be forced to seek re-accreditation by a different entity.

A key question to be addressed is how well current accreditation processes fulfill ACA requirements. Both NCQA and URAC have provided crosswalk materials outlining where their specific accreditation standards correlate to ACA requirements. Similar crosswalk information is available from AAAHC. The states may wish to consider an arrangement where accreditation by one or more of the national organizations will be presumed to show compliance with additional QHP

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<sup>5</sup> For more information about the history and activity of the AAAHC, visit [www.aaahc.org](http://www.aaahc.org).

<sup>6</sup> Proposed Rule, 77 Fed. Reg. 33133 (June 5, 2012).

<sup>7</sup> The conditions are specified in §156.275(c)(2)–(4) of the Proposed Rule on Recognition of Entities. The Proposed Rule noted that NCQA meets, and URAC is planning to meet, these conditions.

<sup>8</sup> This future rulemaking will be 45 CFR §156.275(c)(1)(ii).

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requirements beyond the baseline requirement that all QHPs be accredited. However, in allowing this presumption, the states should not cede regulatory authority, so they can take action if they determine that additional oversight is required.

Although the ACA requires an Exchange to address certain quality-related issues (including evaluating quality improvement strategies, overseeing implementation of enrollee satisfaction, assessments, comparative ratings and outcomes), there may be an opportunity to realize considerable administrative savings, as well as valuable consumer protection, by deferring to the accrediting entities that already address these dimensions as part of their accreditation programs, and have decades of experience, as well. Accreditors report that currently as many as 41 states have some level of accreditor recognition. State certification of accrediting entities, if utilized, should be limited, however, to the state in which it is granted.

Exchanges should also align and prepare to be able to receive and evaluate the data that would be necessary to fulfill accrediting and quality obligations (as established by future guidance on quality reporting by HHS). Accreditation is a tool for regulators and purchasers that does not serve as a replacement for regulatory oversight, but is a complement to state regulatory review. It offers an objective evaluation of critical quality activities (e.g., quality improvement, credentialing or provider directories) not currently included in a state's plan audit processes. For areas where accreditation overlaps with existing state requirements (e.g., utilization management/review) the review can help Exchanges and their state regulatory partners in the assessment of initial and ongoing qualification.

Those states that decide to use the results of accreditation to satisfy some state or federal requirements may wish to be careful to ensure that QHP certification processes do not duplicate the activities of accrediting entities or establish differing regulatory requirements, which could add to administrative costs. The states should consider the extent to which data submitted on the accreditation survey may be used to fulfill other quality reporting standards, and it is anticipated that HHS will issue future guidance to establish when accreditation can fulfill federal quality reporting requirements.

#### **b. Quality Reporting Requirements of QHP Issuers**

While quality reporting requirements for QHP issuers and Exchanges will be the subject of future federal rulemaking, HHS has indicated support for an approach that allows for harmonization of measures across programs. In guidance on federally facilitates Exchanges, HHS stated that they intend "...to solicit stakeholder input on the most effective ways to align the quality reporting and display requirements for QHPs in 2016 and beyond with related quality measurement initiatives across HHS (for example, the National Quality Strategy, section 2717 of the Public Health Service Act (PHSA)), and quality reporting requirements under Medicare and Medicaid."

In the interim, the ACA and the final Exchange rule require that QHP issuers must "be accredited on the basis of local performance by an accrediting entity" recognized by HHS in the following nine categories:

- (i) Clinical quality measures, such as the Healthcare Effectiveness Data and Information Set [HEDIS].
- (ii) Patient experience ratings on a standardized CAHPS survey.
- (iii) Consumer access.
- (iv) Utilization management.
- (v) Quality assurance.
- (vi) Provider credentialing.
- (vii) Complaints and appeals.
- (viii) Network adequacy and access.
- (ix) Patient information programs.

Accreditation programs must include clinical quality measures. In recent proposed rules, CMS put forward the following criteria that clinical measures must meet to satisfy the accreditation clinical quality measure requirement.

- Span a breadth of conditions and domains, including, but not limited to, preventive care, mental health and substance abuse disorders, chronic care and acute care.
- Include measures that are applicable to adults and separate measures that are applicable to children.
- Align with the priorities of the National Strategy for Quality Improvement in Health Care.
- Only include measures that are either developed or adopted by a voluntary consensus standards-setting body (such as those described in the National Technology and Transfer Advancement of Act of 1995 (NTTAA) and Office of Management and Budget (OMB) Circular A-119 (1998)) or, where appropriate endorsed measures are unavailable, are in common use for health plan quality measurement and meet health plan industry standards.
- Be evidence based.

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While the clinical quality measures for NCQA and URAC have similarities and differences, both have undergone initial review by the U.S. Center for Consumer Information and Insurance Oversight (CCIIO) and, thus far, it appears that they will meet HHS requirements. Prior to issuing this proposed rule and identifying NCQA and URAC for potential recognition, CCIIO has worked to become fully aware of the current standards and clinical quality measures employed by both NCQA and URAC. A final review and approval of both URAC's and NCQA's programs, including measures, will be performed by HHS prior to announcing formal recognition in a final rule to be published in the *Federal Register*.

The following chart summarizes the measure set domains for the two accrediting entities, NCQA and URAC, which were named in the proposed rule.

URAC Measures	NCQA (HEDIS <sup>®9</sup> ) Measures
<ul style="list-style-type: none"> <li>• Patient centeredness</li> <li>• Coordination of care</li> <li>• Care efficiency</li> <li>• Effectiveness of care</li> <li>• Patient safety</li> <li>• Health plan management and administration</li> <li>• Systemness or health information technology integration</li> <li>• Health care disparities</li> </ul>	<p>Measures scored in accreditation:</p> <ul style="list-style-type: none"> <li>• Prevention and screening</li> <li>• Respiratory conditions</li> <li>• Cardiovascular conditions</li> <li>• Diabetes</li> <li>• Musculoskeletal conditions</li> <li>• Behavioral health</li> </ul>

Detailed clinical quality measure sets for both URAC and NCQA are available at their respective websites: [www.ncqa.org](http://www.ncqa.org) and [www.urac.org](http://www.urac.org). In addition, information about the AAAHC quality measure sets can be obtained by contacting AAAHC at [info@aaahc.org](mailto:info@aaahc.org).

It should also be noted that, while NCQA has developed and maintained the HEDIS measure set, URAC's program can also accept HEDIS measures for issuers already using that system of reporting. NCQA also can collect and audit non-HEDIS quality measures.

Under the ACA, the states may require quality measures in addition to those required by the accrediting entities. URAC's program allows for the states to supplement its requirements in this manner. The states may also be interesting in asking plans to address certain state-specific data that is not included in reports from accreditors. For example, those states with a significant mining industry may ask health plans in that state to report data and improve the quality of health care services related to illnesses and injuries associated with mining activities. However, the states should consider balancing the imposition of any new quality measures with increased compliance costs, and consider that federal standards will be established in this future.

**c. Sharing of Accreditation Information on QHP Issuers with Exchanges**

45 CFR §156.275(a)(2) requires QHP issuers to “authorize the accrediting entity that accredits the QHP issuer to release to the Exchange and HHS a copy of its most recent accreditation survey, **together with any survey related information that HHS may require** [emphasis added], such as corrective action plans and summaries of findings.” NCQA provides the states with quality measure results. On the other hand, URAC routinely provides the states with a copy of the accreditation summary report, and gives them an opportunity to receive additional information. The accrediting entities recognize that the ACA requires an increased level of information-sharing than has occurred in the past, and goes beyond what the accrediting entities currently make publicly available.

In their proposed rule, HHS proposes that, when authorized by an accredited QHP issuer, the accreditation entities provide certain data elements to the Exchange during the annual certification period or as changes occur to the data throughout the coverage year. These data elements include: name, address, Health Insurance Oversight System (HIOS) issuer identifier, unique accreditation identifier(s) of the QHP issuer and its accredited product(s) and type(s) that have been released. In addition, for each accredited product type: the HIOS product identifier; accreditation status, survey, type or level;

<sup>9</sup> HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

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accreditation score; expiration date of accreditation; and clinical quality measure results and CAHPS measure survey results (for example, QHP product or plan level).<sup>10</sup>

The accrediting entities have expressed interest in working with the federal government, the NAIC and state Exchanges to provide necessary plan accreditation information with the QHP issuer's authorization. In doing so, it is anticipated that the accrediting entities will put in place any necessary data agreements before sharing the information.<sup>11</sup> The proposed rule also provides that Exchanges will be permitted to enter into these types of data-sharing agreements if they choose to require additional information, and asks for additional comment on whether accrediting entities should be required to provide this additional information upon request from an Exchange.

At a minimum, state insurance regulators should receive sufficient information to ensure ACA compliance.

Even if an Exchange is able to use the results of accreditation to satisfy some of the oversight requirements, the Exchange should arrange to have access to the data sets that are collected for accreditation purposes. In doing so, Exchanges should ensure the protection of confidential or proprietary data.

The states should also consider which state agency is appropriate to receive such information, because it might not always be the state insurance department. State insurance regulators are likely already familiar with the NAIC's System for Electronic Rate and Form Filing (SERFF). The NAIC is currently in ongoing discussions with NCQA and URAC regarding SERFF's role as a data conduit in order to present data in a way that is helpful for state review. Those states in full federally facilitated Exchanges may also utilize the HIOS for data exchange. The NAIC's Market Conduct Annual Statement (MCAS) may also be a potential data-sharing platform in the future if large data sets are involved. However, because MCAS is not currently used for health insurance, the development and refinement of a health application for MCAS could be a lengthy endeavor.

Both SERFF and MCAS are tools well known to state insurance regulators, but for those states where the Exchange is not overseen by the insurance department, or in those states where there is a federally facilitated Exchange, these platforms might not be the obvious first choice of the Exchange. HHS has a growing familiarity with SERFF, although state Medicaid and public health agencies are unlikely to be familiar with SERFF. The states may wish to consider the use of these platforms as a means to harmonize with overlapping insurance department and Exchange activities.

#### **d. Requirement to Establish Time Frames for Accreditation**

For QHP issuers that are not already accredited, Exchanges are required to establish a uniform period following certification of a QHP within which the issuer must become accredited.<sup>12</sup> The accreditation requirement depends on the timeline set by an Exchange.

In determining a time frame to achieve accreditation, state insurance regulators should be aware of the reasons that some health plans are not currently accredited. Accreditation has traditionally been driven by public and private purchasers requiring accreditation of plans in order for plans to participate in the market, for plans to receive preferential contracts and to provide or supplement oversight. Prior to enactment of the ACA, some plans decided not to pursue accreditation due to cost. State or regional provider-sponsored plans are less likely to have the preferential contract opportunities or market incentives to dedicate resources to earning formal accreditation. These plans may be aware of accreditation evaluation standards and measures, and strive to comport themselves following those standards, although it is not possible to determine whether the non-accredited plans are, in fact, meeting industry standards and measures and monitoring quality.

The states may wish to analyze the status of their non-accredited issuers to determine if sufficient criteria exist (based on the plan's documented efforts to operate like an accredited plan) to provide some kind of monetary or technical assistance for those plans to get them to formal accreditation. This may be an especially important consideration for the new Consumer Operated and Oriented Plans (CO-OPs), which have no previous experience operating as a health plan, let alone an accredited

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<sup>10</sup> Proposed Rule on Recognition of Entities, §156.275(c)(5).

<sup>11</sup> The type of data agreement may vary depending on the use of the information. For example, if a state Exchange intends to publicly report information from an accreditation review, a different data agreement may be needed than if a state were intending to use the information solely for QHP certification purposes.

<sup>12</sup> 45 CFR §155.1045.

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health plan.<sup>13</sup> It is reasonable that the states may be concerned about providing assistance to such smaller and newer plans. However, more established insurers that are already accredited and issuers currently undergoing the accreditation process may have objections to the competitive disadvantage posed by assistance to newer and smaller issuers. In addition, state Exchanges should carefully consider, if such an issuer does not have the resources to complete initial accreditation, whether they would have difficulty funding the ongoing costs of maintaining the operational infrastructure to meet the accreditation standards and cost of renewal accreditation fees. In addition, Exchanges may want to weigh this expense against other more pressing needs, given scarce resources.

The accrediting entities are also aware of the challenges facing new plans, such as the CO-OPs, and plans that are not currently accredited but are interested in pursuing accreditation. New issuers will not have a history of complex case management files that can be reviewed or a history of claims that can be used to report clinical quality measures. All three known accrediting entities (NCQA, URAC and AAAHC) have provisional or interim accreditation programs to accommodate these types of situations.<sup>14</sup> It is also anticipated that accreditation standards for multi-state plans, including an accreditation timeline, will be included in future federal rules for multi-state plans.

In guidance on federally facilitated Exchanges, HHS announced accreditation requirements for QHP issuers. In coverage years 2014 and 2015, a QHP issuer will receive an interim accreditation that reflects policies and procedures, not performance. If a QHP issuer has an existing health plan accreditation on a commercial line of business in the same state as the Exchange, and only one product type is accredited (e.g., commercial HMO), that accreditation will apply to all Exchange product types (HMO, PPO, POS) if the policies and procedures that were accredited for the commercial HMO are the same across all product types. If a QHP issuer has no existing accreditation, then the QHP issuer will need to get an interim accreditation in 2014 and 2015. This timeline will also be enforced in Exchange Partnership states.

The guidance also indicates the federally facilitated Exchange will accept NCQA or URAC accreditation of a commercial or Medicaid QHP in the same state in which the issuer is seeking to offer Exchange coverage until the fourth year of certification. This approach is designed to accommodate the needs of new entrants and Medicaid QHPs seeking certification as a QHP.

In establishing a timeline or grace period, the states should be aware that the accrediting entities have indicated that the typical accreditation process for a previously unaccredited issuer takes an average of 18 months to prepare and an additional three months for the accreditor review process. For issuers not already accredited, the January 1, 2014, time frame is achievable because URAC and NCQA both offer provisional or interim accreditation that could be granted in that time frame. However, issuers not currently accredited do not necessarily need to achieve accreditation by January 1, 2014.

As of the date of this paper, several of the states have already established Exchanges, and have had varying experience in establishing time frames for accreditation. For example, the Arizona Health Insurance Exchange allows issuers to have one year from the date of application to sell a product in their Exchange to demonstrate accredited status. Arizona's decision was based on informal work with health plans and consumer advocates and was informed by the fact that most non-accredited issuers were already well on their way toward accreditation.

The states also will need to determine the manner in which they establish the time frame, including whether it will require a rule or statute. Arizona simply published its decision. Exchanges in other states might find it necessary to establish the time frame in a more formal manner, such as via bulletin, regulation or statute.

The states may also need to consider what will occur if an issuer attempts but fails to achieve accreditation by the expiration of the required time frame. Historically, the formal accreditation process was sufficiently resource-intensive that issuers

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<sup>13</sup> 45 CFR §156.515(c)(2) states: "Loan recipients must offer a CO-OP qualified health plan ... in every individual market Exchange ... If offering at least one plan in the small group market, loan recipients must offer a CO-OP qualified health plan in each SHOP ..."

<sup>14</sup> URAC grants provisional accreditation if the plan meets standards for policies and procedures, but does not yet have sufficient operational experience or consumer enrollment to receive full accreditation. Once the plan does have operational experience with enrolled consumers, URAC will conduct an on-site review to validate compliance with accreditation standards. NCQA has created interim and first accreditation programs for new or currently unaccredited issuers and will first review policies and procedures, then review plan files and performance once the plan builds a history of enrollment. AAAHC's Early Options Survey (EOS) program is for plans in operation for six months or less, and plans are granted accreditation but must then undergo an additional interim survey during the accreditation term.

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would not pursue accreditation if they were not reasonably confident they would succeed. Issuers may also have feared negative publicity resulting from an accreditation denial. URAC has corrective-action requirements for organizations undergoing accreditation review and NCQA provides feedback to plans on areas with poor performance and allows plans second review if plans are denied accreditation initially. There are some built-in measures to manage situations of denied accreditation; however, the states should consider ramifications if decertification is required. For example, if denied, an issuer can have an additional six months to correct its performance and then undergo an expedited review by the accreditor.

A related topic the states should consider is what types of consequences should result from decertifying a QHP due to failure to achieve accreditation within the specified time period. For example, while an individual may still have guaranteed renewability rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), if their plan is decertified for failure to achieve accreditation, their plan would no longer be available on the Exchange. Similarly, issues surrounding state subsidies should be considered. If an enrolled individual's chosen plan is decertified, subsidies are not available outside the Exchange, even though HIPAA gives those individuals a right to guaranteed renewability. The states may also want to consider implications for small employers purchasing coverage in the Small Business Health Options Program (SHOP) Exchanges.

The states may wish to inquire with accrediting entities about timing based on the volume of issuers in their states that have approached them about accreditation since enactment of the ACA. In those states that currently have many of the plans accredited for other commercial, Medicaid or Medicare products, there will not be a large influx of plans, and the accrediting entities may perform a shorter and limited review of those plans that are currently accredited. State insurance regulators may also want to keep in mind that additional accreditation entities may seek to play a larger role in accreditation of issuers to meet demand and preserve competition (although under the proposed rule, only specific named accreditors will be recognized by HHS on an interim basis).

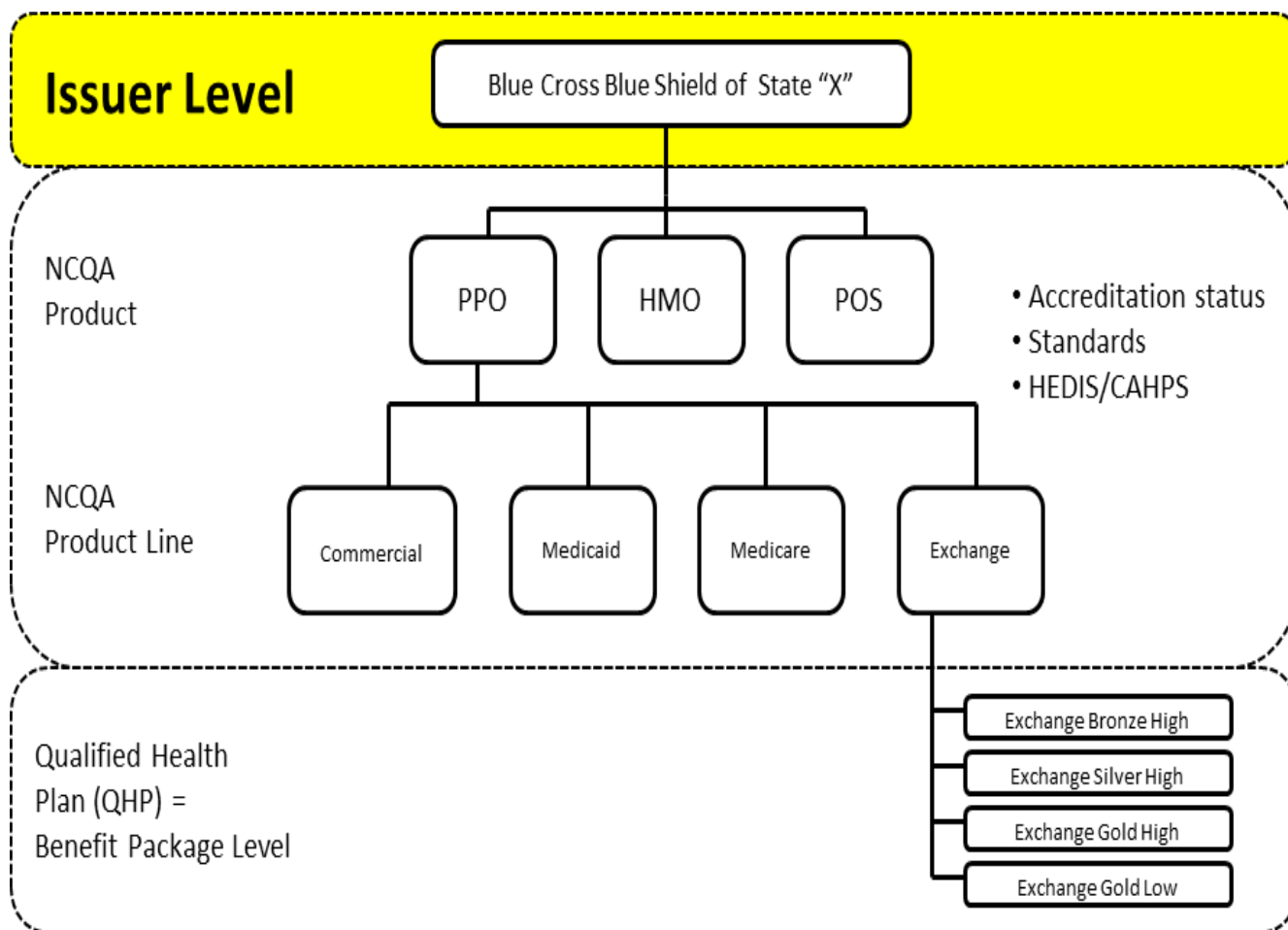
**e. How Well Does Accreditation Line Up with Policy Forms?**

There is considerable confusion in the ACA, related to federal regulations and various external information sources in how the terms “plan” and “product” are defined and used. For state insurance regulators, there may not be much, if any, distinction for regulatory purposes between these terms. Existing federal laws — such as HIPAA, Mental Health Parity and Addiction Equity Act (MHPAEA) and ERISA, and now the ACA — attach different meanings to these terms. To complicate matters, URAC and NCQA accreditation status is awarded to entities that may or may not be recognizable to state insurance regulators. It is clear from materials available from URAC and NCQA that accreditation could be issued in a variety of ways: to an insurance company, a holding company, a single product or product line within a company but NOT the whole company, one geographic part of a company's total geographic territory, etc. Accrediting entities have expressed interest in working with the NAIC to match levels of accreditation to NAIC codes.

Currently, each URAC accreditation attaches directly to a state-licensed issuer and applies to all lines of the issuer's business in a given state (e.g., QHP, commercial, Medicaid). So, for example, in the case of a national insurer that operates QHP issuers in multiple states, a URAC accreditation certificate number is not issued to the parent company. Instead, each state-licensed QHP issuer operated by the parent company receives a separate on-site review by URAC and receives its own unique URAC accreditation certificate.

In conducting the on-site review, URAC verifies that the name of the legal entity seeking accreditation is directly matched to a state insurance license. URAC also conducts a review to ensure that each product offered by the issuer (e.g., HMO, PPO, POS) and every product line (QHP, commercial, Medicaid) meets URAC accreditation standards, as well as any state-specific requirements. When URAC issues an accreditation certificate, it is specific to a state-licensed issuer and the certificate lists each product and product line that is included in the accreditation. URAC has indicated that they could also list on the certificate the state license identifier and NAIC code for the accredited entity. However, the states should verify that the accreditation achieved is the appropriate level for qualification for the Exchange.

The following chart, supplied by NCQA, demonstrates what level NCQA accreditation and quality data-collection occurs.



The challenge with this approach, for state insurance regulators, is that it does not resemble or correlate to state licensure, market regulation or solvency laws, which are the general parameters by which state insurance regulators recognize a “plan.” For example, in many of the states, licensure as an insurance company precludes the sale of HMO products, and vice versa. Licensure as an HMO precludes the sale of insurance products. That is, there would not be one company delivering both PPO and HMO products under the same license. Therefore, the accreditation that NCQA’s chart indicates actually would apply to at least two separately licensed entities in the eyes of the state insurance regulators. Yet only one accreditation has been awarded from NCQA.

In many cases, it may not be easy for the states to identify which insurance policies or products or plans line up with an accreditation and which ones do not. This is an area where SERFF might be useful. SERFF staff have worked closely with state and federal officials to adapt SERFF to meet new needs under the ACA. When making a policy form filing in the SERFF system for state-approval purposes, the SERFF system could be adapted to reflect whether the company proposes to use the form(s) in that filing in or out of the Exchange, or both, as well as the evidence of accreditation status necessary if the form is for purposes of supporting plans sold through the Exchange. If necessary, the states could establish state-specific submission requirements in SERFF, although doing so might create a lack of uniformity across the states.

In their June 1, 2012, proposed rule, HHS proposed that accreditation should be done for each product type offered by a QHP issuer in each Exchange, based on data submitted by the issuer that is representative of the population of each QHP in that Exchange product type.<sup>15</sup>

Consumer groups note that QHP accreditation, rating and reporting should be tied as closely as possible to the particular plan in which an individual is enrolling, in order to permit consumers to make plan comparisons based on quality and the most transparency. They oppose accreditation at the holding company level.

<sup>15</sup> 45 CFR §156.275(c)(2)(iii).



Both NCQA and URAC have demonstrated unhesitating willingness to work closely with state and federal regulators to ensure smooth implementation of the ACA requirements. This cautionary note is simply to advise state insurance regulators to pay close attention to the details of accreditation awards.

#### **f. Dental Plans**

Stand-alone dental plans offered in an Exchange are considered to be a type of QHP. These plans must meet consumer protection standards, such as offering benefits without annual and lifetime limits.<sup>16</sup> However, the federal rule recognizes the unique nature of stand-alone dental plans and permits Exchanges to establish standards that are specific to stand-alone dental plans. The final rule also establishes that stand-alone dental plans must comply with QHP certification standards, except for those certification standards that cannot be met because the plans covers only pediatric dental benefits. To the extent that accreditation standards specific to stand-alone dental plans do not exist, such plans would not have to meet the requirement that QHPs not already accredited must become accredited within the uniform period established by Exchanges.<sup>17</sup>

There are currently no accreditation standards specifically for dental plans. It does not appear that such standards are likely to be developed by the health plan accrediting entities specifically for dental plans. Dental plans believe, and urge, that accreditation standards should not be applicable to dental.

The states should be aware that URAC does currently accredit a few dental plans to varying degrees. URAC's accreditation is offered in modular format, for specified activities (such as utilization management, for example). These can be applied to a broad range of entities that perform utilization management, including dentistry. Therefore, some of URAC's accreditation awardees are dental plans that have earned accreditation in a module applicable to the business of operating a dental plan (such as utilization management). The states may wish to consider if a particular URAC module is reasonable to expect a certified dental plan to obtain. In considering this option, however, the states should keep in mind that extremely few dental plans have any accreditation, and that for pediatric-only dental plans, the costs and administrative burden of accreditation may outweigh any benefit.

#### **g. CO-OPs**

Neither the ACA nor federal regulations regarding CO-OPs provide an exception for CO-OPs in terms of obtaining accreditation for their QHPs, or for complying with quality reporting requirements. Because CO-OPs are intended to have no connection to any existing insurance plans, CO-OPs will, therefore, have no experience, no maturity with data-collection and reporting, and no statistically valid pool to sample, or from which to pull data. The federal regulations establish a phase-in time frame for new plans to earn accreditation. However, given CO-OPs' lack of claims experience, the application of the accreditation and quality requirements to CO-OPs will be particularly challenging. URAC's modular options for accreditation, as discussed above in relation to dental plans, may be a suitable and appropriate route for CO-OPs.

### **4. Quality Elements in the Exchanges**

The federal regulation requires Exchanges to evaluate quality improvement strategies and oversee implementation of enrollee satisfaction surveys, assessment and ratings of health care quality and outcomes, information disclosures and data-reporting.<sup>18</sup>

#### **a. Requirement to Evaluate Quality Improvement Strategies**

The ACA requires QHP issuers to implement a quality improvement strategy. This is a requirement separate from the accreditation process. Exchanges are required to evaluate these quality improvement strategies.<sup>19</sup> As of the date of this paper, HHS has not issued additional guidance, although such guidance is anticipated. At present, this paper will assume that Exchanges will collect data from QHP issuers that shows health status and health outcomes.

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<sup>16</sup> 45 CFR §155.1065.

<sup>17</sup> Exchanges Final Rule, Provisions of the Proposed Regulation and Analysis and Response to Public Comments, p. 18412 describing §155.1065 and §155.1045.

<sup>18</sup> ACA, Section 1311(c)(1), 1311(c)(3) and 1311(c)(4).

<sup>19</sup> 45 CFR §155.200(d) states: "*Quality activities:* The Exchange must evaluate quality improvement strategies...in accordance with sections 1311(c)(1), 1311(c)(3), and 1311(c)(4) of the Affordable Care Act."

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HHS intends to propose a phased approach to new quality reporting and display requirements for all Exchanges and expects that state-based Exchanges may adopt a similar approach prior to final regulatory standards. It is anticipated, for example, that HHS will propose that reporting requirements related to all QHP issuers will start in 2016. It is also anticipated that HHS intends to support the calculation of the QHP-specific quality rating for all QHP issuers in all Exchanges. The QHP-specific quality rating would be available for display in 2016 open enrollment for the 2017 coverage year. In the interim, a federally facilitated Exchange will display existing CAHPS data that are available for the same QHP product types and adult/child populations from existing accreditation data.<sup>20</sup> Federally facilitated Exchanges will not display other data drawn from the accreditation data, such as clinical measures results.

HHS intends to engage in rulemaking for quality reporting and disclosure requirements for all Exchanges. HHS also intends to solicit stakeholder input on the most effective ways to align the quality reporting and display requirements for QHPs in 2016 and beyond with related quality measurement initiatives across HHS (for example, the National Quality Strategy, Section 2717 of the PHSA, and quality reporting requirements under Medicare and Medicaid).

The statutory language regarding quality improvement strategies refers to “market based incentives.” These are defined as “increased reimbursement” or other incentives for specified outcomes or implementation of certain activities. Therefore, it appears that, at a minimum, “quality improvement” means more money for achieving outcomes or implementation activities. The use of the term “reimbursement” appears to assume the incentive is aimed at those who are reimbursed by health plans. In most cases, medical providers are reimbursed by health plans. It appears that the intent of the ACA is that QHP issuers will pay providers more if providers demonstrate achievement of desired outcomes. “Other incentives” can certainly mean almost anything, including, but not limited to, reduced out-of-pocket costs for health plan members.

Although accreditation programs could be used to demonstrate how plans are meeting quality improvement strategies, it is unclear, pending further federal guidance, whether accreditation will be considered sufficient to meet such quality improvement strategies. Both URAC’s and NCQA’s health plan accreditation programs include standards related to operation of an effective internal quality improvement program which, in part requires analyzing performance based on quality measures, and conducting corrective action and follow-up based on these findings.

Consumer groups suggest that the goal of establishing quality improvement strategies is to help provide incentives for providers to provide, and for consumers to choose, the highest quality, highest value health plans and providers. For providers, these may include incentives to implement patient-centered care initiatives that focus on improving health outcomes, preventing readmissions, improving care coordination, advancing patient safety, reducing medical errors and reducing disparities in care. For consumers, this would encourage the use of services and programs that improve health and may include the use of patient-centered tools designed to discourage utilization of expensive services that do not add value when good alternatives exist. QHPs may be able to demonstrate quality improvement strategies by making a commitment to higher reimbursement for primary care, increased access to primary care services, and adopting strategies toward achieving a coordinated, patient-centered, value-based delivery system.

The states may want to address state-specific health issues in their review of QHPs’ quality improvement strategies, and to ensure that the strategies are consistent with the three-part aim identified in the National Quality Strategy: better care, healthy people and communities, and affordable care.<sup>21</sup>

Consumer groups have suggested that HHS establish a standardized set of metrics that the NAIC can adopt to ensure comparability across QHPs and state Exchanges. However, insurers have raised concerns that quality improvement strategies will not be comparable across plans because of population differences and socioeconomic factors and, therefore, would not be an accurate reflection of the effectiveness of such programs. One potential challenge to quality reporting in the Exchange relates to the expected influx of individuals who have not previously had access to coverage. These individuals will likely have unmet health needs that will affect initial efforts to improve quality. At least initially, measurements of quality improvement are expected to be unreliable as a significant volume of previously uninsured people are introduced into the system. Guidance related to federally facilitated Exchanges provides for a phase-in of quality reporting requirements to account for this initial instability.

In order to assist state Exchanges in evaluating quality improvement strategies, the states may also want to consider some potential tools such as SERFF, all-payer claims databases and MCAS (described earlier in this paper).

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<sup>20</sup> For example, HMO Adult CAHPS results for HMO QHPs, or Child CAHPS results for child-only QHPs.

<sup>21</sup> For more information about the National Quality Strategy, visit [www.ahrq.gov/workingforquality/nqs](http://www.ahrq.gov/workingforquality/nqs).

## 1. SERFF

SERFF is an NAIC-owned, Internet-based tool used by 49 states, the District of Columbia and Puerto Rico, as well as more than 3,400 insurers, for purposes of submitting, receiving, reviewing and approving insurance company product filings (e.g., rate, form, rule and advertising). The SERFF system has automated the historically manual, paper-intensive filing process. Today, it is estimated that more than 95% of all product filings travel through the SERFF system. NAIC SERFF staff have been actively working with state insurance regulators, insurers, the federal government and other third parties, such as URAC and NCQA, to explore adaptations that would support health plan management functions that the states may elect to perform in a health insurance Exchange, regardless of the Exchange model implemented (state-based, Partnership or federally facilitated exchange). State insurance regulators and the health insurance industry agree that they would benefit significantly in terms of administrative consistency and support if the SERFF system could be modified to support QHP issuer accreditation and quality improvement data. SERFF staff have already proven that they are willing and able to modify the SERFF system to support new functions related to the federal health insurance reforms in other areas, notably in support of health insurance rate review functions and data reporting to the federal government.

Current plans are under way to ensure that SERFF will serve a role in the new Exchange environment. Details related to the role of SERFF, as the primary plan management tool, have been evaluated. Phase 1 of this initiative was approved as part of the NAIC's 2012 budget process and Phase 2, while currently under way, will be formally approved in the upcoming 2013 budget process. Modifications to the SERFF system will be funded by the states through their federal grant funds, either for exchanges or rate review.

## 2. All-Payer Claims Databases

Some states have implemented an all-payer claims database (APCD) that could potentially be used to evaluate quality improvement strategies and oversee plan quality.<sup>22</sup> APCDs are enjoying some popularity among policymakers because of the potential to gather, control, analyze and manipulate a tremendous amount of public health information.

However, it is important to note that, thus far, APCDs are claims databases and do not collect information on quality initiatives or outcomes. For purposes of this paper, both the medical provider community and the health insurance industry have expressed significant concern with the state of development of APCDs and the use of APCDs in the 14 states that have enacted legislation to collect claim or remittance information.

To address some of the complex data challenges, the Accredited Standards Committee X12 and the APCD Council are currently attempting to develop a national standard (or standards) for reporting from APCDs. Though the X12 standards may clarify some reporting issues, these standards might not address other issues, such as inconsistent data definitions among payers, which is one of the major impediments to using APCDs' information for comparative quality reporting purposes. The technology is considered to be still under development and it may be many years before APCDs can be expected to serve a significant role in state health planning.

### b. Requirement to Oversee Implementation of Enrollee Satisfaction Surveys

It is anticipated that HHS will issue further guidance on implementation of enrollee satisfaction surveys, which are intended to survey consumer satisfaction with QHPs in Exchanges. Specific reference in the ACA is made to Consumer Assessment of Healthcare Providers and Systems (CAHPS) and HHS plans to develop an enrollee satisfaction survey based on CAHPS.<sup>23</sup> CAHPS surveys ask consumers and patients to report on and evaluate their experiences with health care. The survey is a set of instruments established and maintained by the federal Agency for Healthcare Research and Quality (AHRQ). However, AHRQ does not administer the survey. It is publicly available and is nationally recognized as a valid and uniform instrument for surveying consumer satisfaction with health care service delivery and financing systems.

NCQA currently uses CAHPS surveys. URAC has routinely accepted CAHPS data as part of meeting its standards and, with the release of the current URAC Health Plan Accreditation Program (Version 7, 2011), URAC now requires CAHPS reporting.

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<sup>22</sup> More information about APCDs is available at [www.apcdouncil.org](http://www.apcdouncil.org) and [www.x12.org](http://www.x12.org).

<sup>23</sup> For more information, visit [www.cahps.ahrq.gov](http://www.cahps.ahrq.gov).

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The ACA requires Exchanges to “oversee implementation of enrollee satisfaction surveys.”<sup>24</sup> The Exchange must also post enrollee satisfaction survey results on the Exchange website so that the public can compare satisfaction across plans. The states can elect to deem an accredited plan to meet any state-specific standards for surveying consumer satisfaction.

Several different survey instruments are available, including “Health Plan,” “Clinician and Group,” “Hospital” and others. One survey instrument that does not currently exist is “Exchange.” Therefore, where the ACA and associated regulations require state Exchanges to “oversee” surveys of consumer satisfaction, it appears this refers to surveys of consumer satisfaction with the health plans specifically sold as QHPs through the Exchanges. It does not appear that Exchanges must directly administer such surveys, but Exchanges are responsible for overseeing surveys administered by QHPs on their own membership. This is another area, however, where it would be questionable for Exchanges to duplicate the work already being carried out by the accrediting entities. To the extent permitted by future federal guidance, Exchange activity in this area should defer to accreditation standards. Exchanges may want to consider whether they want to voluntarily undertake their own customer satisfaction surveys, specifically because there is currently no CAHPS instrument specific to “Exchange.” However, the states should keep in mind that HHS will be implementing a survey for all QHPs.

**c. Requirement to Support a Website that Provides Standardized Comparative Information on Quality Ratings**

It is anticipated that further regulatory guidance will be issued before Exchanges are required to implement a quality rating system. It is anticipated that HHS intends a phased approach to the quality rating provisions in which quality ratings in 2014 would be predicated on generally available and collected metrics and measures, and moving to a QHP-specific rating in 2016. Once implemented, it is part of the obligation of Exchanges to oversee implementation of “assessment and ratings of health care quality and outcomes, information disclosures and data reporting.”<sup>25</sup>

Numerous organizations across the country have websites providing comparative information on health plans. Quality reporting information on such comparative websites, in conjunction with cost information, will assist consumers in making decisions based on value. The Massachusetts Health Connector website, which includes data on accreditation and quality, is one resource the states may wish to look at as they design and implement a quality rating system.<sup>26</sup> Another helpful example may be the Getinsured.com website, which also displays accreditation information.<sup>27</sup> A third useful tool is the Consumers CHECKBOOK plan compare tool.<sup>28</sup>

There are additional requirements in the ACA and Exchange regulations on what the Exchange website should support, but, for purposes of this paper, the focus is on allowing consumers to compare plans on a quality and price basis, where certain minimum required plan features are expected to be the same across all plans, such as coverage for preventive services and essential health benefits. State Exchanges may want to develop their quality initiatives closely in concert with the development of the Web portal and other consumer assistance tools, to ensure that the quality measurement efforts will support and contribute to the use of this information by consumers.

When thinking about providing quality information to Exchange enrollees on websites, NCQA has suggested two phases of presenting this type of information. In the early years, there will be limited quality information available because there is no Exchange population to measure. In this first phase of the Exchange, the websites can report how a plan performed on accreditation. URAC urges that, because access to health plan quality information is essential to consumers, this information would be the most widely available to consumers when provided through the Exchange websites.

**d. Quality Best Practices and Related Issues**

The states have a variety of options to evaluate and adopt best practices in health care and health plan quality oversight.

There are a number of organizations devoted to improving quality in the health care context. AHRQ, described above, is the lead federal agency responsible for improving the quality, safety, efficiency and effectiveness of healthcare for Americans.

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<sup>24</sup> 45 CFR §155.200(d) and ACA Section 1311(c)(4).

<sup>25</sup> 45 CFR §155.200(d).

<sup>26</sup> [www.mahealthconnector.org/portal/site/connector](http://www.mahealthconnector.org/portal/site/connector).

<sup>27</sup> [www.getinsured.com](http://www.getinsured.com).

<sup>28</sup> [www.checkbook.org/plancompare](http://www.checkbook.org/plancompare).

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Other federal agencies, as well as some state-based organizations and private and public-private partnerships, are also involved in quality-related activities.

While this paper is focused on accreditation and quality requirements relating to Exchanges, state insurance regulators have other responsibilities related to insurer quality and reporting under the ACA. Implementation of these related areas should be carefully coordinated. Section 2717 of the PHSA requires HHS to develop reporting requirements for plans regarding coverage provisions and provider reimbursement structures intended to improve outcomes, reduce hospitalizations and improve patient safety, among other goals. Section 2715(a) of the PHSA, Section 1311(e) of the ACA and Section 2718 of the PHSA require issuers to report data to the Exchange, the state insurance department and HHS. State insurance departments may also want to carefully monitor quality improvement activities for which carriers claim expenses in the numerator of their medical loss ratio (MLR) calculations under Section 2718 of the PHSA.

Accrediting entities offer information and guidance on best practices. According to NCQA, 41 states currently use its accreditation information in their oversight of health plans. Of those, 37 apply it to commercial plans and 29 apply those requirements for Medicaid-contracted plans. Commercial state regulators vary in their use of accreditation, but the most commonly recognized standards include the areas of utilization management and credentialing.

There is an NAIC *Quality Assessment and Improvement Model Act* (#71). One state (Nebraska) has adopted it in total, and 26 states are identified as having adopted it in part, although, in some cases, the requirements only apply to HMOs.

Many of the states have a long history of using elements (e.g., utilization management and credentialing) of or whole quality programs (health plan accreditation) from accreditors. State Medicaid programs have historically been more active in the review of health plan quality than state insurance regulators, through state Medicaid managed care programs. The states can tap their Medicaid managed care programs for guidance and support in developing quality oversight programs applicable to commercial health insurance.

In Tennessee, the TennCare program participated in a webinar with Academy Health and NCQA regarding quality. While the states should consider the differences between Medicaid and commercial insurance markets, the TennCare officials offered the following items as important “lessons learned” in their 15+ years of overseeing a state-wide effort at improving quality for Medicaid beneficiaries:

1. Access to reliable encounter data as quickly as possible is extremely important. Hard data is needed to dispel misinformation.
2. Quality requirements should be spelled out for health plans; e.g., accreditation requirements and timelines and performance measure reporting requirements. Accreditation takes time, so clear milestones should be established to assess progress toward the goal. Consider a pay-for-performance arrangement to reward plans for the accreditation level received.
3. Independent, external review (an external quality review organization (EQRO) or an accrediting entity like NCQA or URAC) goes a long way to quelling stakeholder concerns.
4. Required reporting of standardized, evidenced-based performance measures for managed care organizations (MCOs) allows tracking trends over time and for comparison to national norms (e.g., HEDIS).
5. Consider developing a state-level survey that will allow the tracking of issues of interest to the state over time. This would be in addition to MCO-level surveys like CAHPS.
6. Pay-for-performance incentives tied to specific performance measures can be used effectively to target attention to the state’s highest priorities.
7. Network monitoring should include three components:
  - Establishment of network standards for various provider types (e.g., geographic, appointment time).
  - Tracking compliance with standards based on network information self-reported by MCOs.
  - An audit process to validate MCO self-reported information
8. Tracking and analysis of enrollee appeals can be an important quality monitoring tool.

The Medicaid Health Plans of America (MHPA) offers guidelines for Medicaid managed care programs in specific clinical issues to enhance the overall health of Medicaid populations. Their website also offers access to a wide range of clinical, administrative and policy publications, many at no cost. Other public and private organizations, from consulting firms to research organizations to advocacy groups, offer a wide range of papers, discussions, research articles, webinars and other resources for little or no cost, exploring a wide range of issues in health plan quality improvement strategies. Common themes that appear to recur in much of this literature include:

- The importance of data-collection and state-of-the-art data systems that can support powerful analysis.

- An emphasis on clinical quality measures, with somewhat less information and guidance on administrative quality improvement approaches.
- An emphasis on behavioral incentives for medical providers and patients, beyond clinical excellence. In other words, the best clinical care can be ineffective if not accompanied by incentives that remove administrative barriers to delivery. Proper and timely communication between providers and patients is an important goal.
- Achieving an appropriate balance between data reporting and collection and minimizing unnecessary and unhelpful administrative burdens. The public wants standardized, comparable health plan information, often in highly specialized areas, such as treating children with autism or longevity following cancer treatment. The public also wants privacy protection and affordable care. These two things actually work against each other and will require constant monitoring and perpetual rebalancing.

## **5. Distinctions Based on Exchange Status**

Exchanges may be entirely state-based, or the states may develop a Partnership Exchange with HHS to share certain Exchange responsibilities. Even if the Exchange is entirely federally facilitated, the states should be aware of the quality and accreditation issues. Those states with existing state law requirements for health plan accreditation and quality may be well positioned to manage Exchange operations related to these requirements.

Regardless of the Exchange status, state insurance regulators will play a modified role in health plan oversight. Where the Exchange is operated by the state, the role of state insurance regulators will not change much, as might be the case with a federally facilitated Exchange, but there will still be a change. For example, in areas of market conduct and consumer support, state insurance regulations may be superseded by new Exchange requirements. Insurance regulatory interactions with Medicaid managed care plans and state Medicaid agencies will be dramatically different. Even in the area of health plan solvency, state insurance regulators will be dealing with the financial impacts of new plan growth, new plans in the market place (particularly CO-OPs with no prior insurance experience), and large numbers of new entrants into the insurance market. Although the ACA includes no new financial solvency requirements, state insurance regulators will be wise to keep close track of the financial stability of health plans operating in a fundamentally different market than has existed prior to the ACA.

In those states where there is a Partnership Exchange, state insurance regulators will develop new relationships with their federal partners for the exchange of information and resources. In addition to supplying information to federal partners, state insurance regulators will have a new opportunity to receive information from federal partners regarding the behavior of health plans in the new marketplace. The history of state insurance regulators working together will serve the states well in designing relationships with federal partners that are both responsive to unique needs from state to state, and also uniform where necessary and appropriate.

Finally, state insurance regulatory relationships with regulated health plans, and with consumers, will continue to be critical. Particularly with regard to the role of accreditation, the ability of state insurance regulators to evaluate health plan quality, and the impact of new reporting requirements, the states' ongoing communication with industry and consumers will remain a significant component and will continue to demand significant resources from state insurance regulatory agencies. This will be true, regardless of which type of Exchange is established in a particular state.

## ACA Quality and Accreditation Requirements Related to Exchanges

**Note:** Critical “musts,” “shalls” and “requires” are highlighted in the excerpts below from ACA and from subsequent federal regulations, related to Exchanges and QHP accreditation and quality. The highlighted excerpts formed the basis for the organization of this paper.

### SEC. 1311

...  
(c) *Responsibilities of the Secretary-*

(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—

...  
(D)(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, as well as 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;

(E) *implement a quality improvement strategy* described in subsection (g)(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; and (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. *As added by section 10203(a).*

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(3) **RATING SYSTEM.**—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 individuals and employers through the Internet portal established under paragraph (4).

(4) **ENROLLEE SATISFACTION SYSTEM.**—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.

(5) **INTERNET PORTALS.**—The Secretary shall—

(A) continue to operate, maintain, and update the Internet portal developed under section 1103(a) and to assist states in developing and maintaining their own such portal; and

(B) make available for use by Exchanges a model template for an Internet portal that may be used to direct qualified individuals and qualified employers to qualified health plans, to assist such individuals and employers in determining whether they are eligible to participate in an Exchange or eligible for a premium tax credit or cost sharing reduction, and to present standardized information (including quality ratings) regarding qualified health plans offered through an Exchange to assist consumers in making easy health insurance choices. Such template shall include, with respect to each qualified health plan offered through the Exchange in each rating area, access to the uniform outline of coverage the plan is required to provide under section 2716 of the Public Health Service Act and to a copy of the plan’s written policy.

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(d) **REQUIREMENTS.**—

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(4) **FUNCTIONS.**—An Exchange shall, at a minimum—

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(D) assign a rating to each qualified health plan offered through such Exchange in accordance with the criteria developed by the Secretary under subsection (c)(3);

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(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) 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)....

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**§ 155.1045 Accreditation timeline.**

The Exchange must establish a uniform period following certification of a QHP within which a QHP issuer that is not already accredited must become accredited as required by § 156.275 of this subtitle, except for multi-State plans. The U.S. Office of Personnel Management will establish the accreditation period for multi-State plans.

**§ 156.275 Accreditation of QHP issuers.**

(a) *General requirement.* A QHP issuer must:

(1) **Be accredited** on the basis of local performance of its QHPs in the following categories by an accrediting entity recognized by HHS:

- (i) Clinical quality measures, such as the Healthcare Effectiveness Data and Information Set;
- (ii) Patient experience ratings on a standardized CAHPS survey;
- (iii) Consumer access;
- (iv) Utilization management;
- (v) Quality assurance;
- (vi) Provider credentialing;
- (vii) Complaints and appeals;
- (viii) Network adequacy and access; and
- (ix) Patient information programs, and

(2) **Authorize the accrediting entity that accredits the QHP issuer to release to the Exchange and HHS a copy of its most recent accreditation survey**, together with any survey-related information that HHS may require, such as corrective action plans and summaries of findings.

(b) *Timeframe for accreditation.* A QHP issuer must be accredited within the timeframe established by the Exchange in accordance with § 155.1045 of this subchapter. **The QHP issuer must maintain accreditation** so long as the QHP issuer offers QHPs.

**§ 155.200 Functions of an Exchange.**

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(d) *Quality activities.* The Exchange must evaluate quality improvement strategies and oversee implementation of enrollee satisfaction surveys, assessment and ratings of health care quality and outcomes, information disclosures, and data reporting in accordance with sections 1311(c)(1), 1311(c)(3), and 1311(c)(4) of the Affordable Care Act.

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**§ 155.205 Consumer assistance tools and programs of an Exchange.**

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(b) *Internet Web site.* The Exchange must maintain an up-to-date Internet Web site that meets the requirements outlined in paragraph (c) of this section and:

(1) **Provides standardized comparative information on each available QHP, including** at a minimum:

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- (iv) **The results of the enrollee satisfaction survey, as described in section 1311(c)(4) of the Affordable Care Act;**
- (v) **Quality ratings assigned in accordance with section 1311(c)(3) of the Affordable Care Act;**

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**§ 156.200 QHP issuer participation standards.**

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(b) *QHP issuer requirement.* A QHP issuer must—

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(5) Implement and report on a quality improvement strategy or strategies consistent with the standards of section 1311(g) of the Affordable Care Act, disclose and report information on health care quality and outcomes described in sections 1311(c)(1)(H) and (I) of the Affordable Care Act, and implement appropriate enrollee satisfaction surveys consistent with section 1311(c)(4) of the Affordable Care Act;

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**General Guidance on Federally-facilitated Exchanges, CCIIO (May 16, 2012)**

**Note:** Only a portion of the references to accreditation and quality in this guidance are included in this excerpt.

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**Accreditation and Quality Reporting**

The Affordable Care Act includes several provisions to improve the quality of care delivered by QHPs and increase the availability of quality data that can inform plan selection. Specifically, the Affordable Care Act requires QHP issuers to implement quality improvement strategies, enhance patient safety through certain contracting requirements, and publicly report quality data. In addition, the Affordable Care Act directs the Secretary to develop and administer a rating system and an enrollee satisfaction survey system, the results of which will be available to consumers. HHS intends to issue future rulemaking on quality reporting and disclosure requirements.

QHP issuers participating in an FFE will be required to be accredited by an accrediting entity and comply with quality reporting requirements that HHS will specify in future rulemaking. HHS intends to propose a phased approach to accreditation and quality data reporting and display in an FFE to accommodate new QHP issuers and Medicaid plans without Exchange or accreditation experience.

HHS also intends to propose a phased process for recognizing accrediting entities. In phase one, the entities that HHS believes will be equipped to provide the statutorily required accreditation review by 2013 certification – the National Committee for Quality Assurance (NCQA) and URAC – would be recognized as accrediting entities on an interim basis subject to conditions. In phase two, we would adopt an application and review process for the recognition of additional accrediting entities.

We intend to propose that an FFE will accept existing health plan accreditation from NCQA and URAC on issuers' commercial or Medicaid lines of business in the same state in which the issuer is seeking to offer Exchange coverage until the fourth year of certification (for example, 2016 certification for the 2017 coverage year). HHS intends to propose that QHP issuers without this existing accreditation must schedule this accreditation in their first year of certification and be accredited on QHP policies and procedures by the second year of certification. By the fourth year of certification, all QHP issuers must be accredited on the QHP product type having fulfilled the requirements to submit performance data to the accrediting entity.

Similarly, HHS intends to propose a phased approach to new quality reporting and display requirements for all Exchanges and expects that State-based Exchanges may adopt a similar approach prior to final regulatory standards. For example, HHS intends to propose that reporting requirements related to all QHP issuers will start in 2016. HHS intends to support the calculation of the QHP-specific quality rating for all QHP issuers in all Exchanges. The QHP-specific quality rating would be available for display in 2016 open enrollment for the 2017 coverage year. In the interim, an FFE will display existing Consumer Assessments of Healthcare Providers and Systems (CAHPS) results from accredited commercial and/or Medicaid product lines when these existing CAHPS data are available for the same QHP product types and adult/child populations (for example, HMO Adult CAHPS results for HMO QHPs, Child CAHPS results for child-only QHPs). FFEs will not display other data drawn from the accreditation data, such as clinical measures results.

HHS intends to engage in rulemaking for quality reporting and disclosure requirements for all Exchanges. HHS also intends to solicit stakeholder input on the most effective ways to align the quality reporting and display requirements for QHPs in 2016 and beyond with related quality measurement initiatives across HHS (for example, the National Quality Strategy, section 2717 of the Affordable Care Act, and quality reporting requirements under Medicare and Medicaid).

Adopted by the NAIC Health Insurance and Managed Care (B) Committee on June 27, 2012  
Intended for Use by the States as Guidance Only

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**Proposed Rule on Recognition of Entities for the Accreditation of Qualified Health Plans, CMS-9965-P, 77 Fed. Reg. 33133-142 (June 5, 2012)**

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**§ 156.275 Accreditation of QHP issuers.**

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(c)(1) *Recognition of accrediting entity by HHS.*

(i) Effective upon completion of conditions listed in paragraphs (c)(2) through (4) of this section, at which time HHS will notify the public in the **Federal Register** that the National Committee for Quality Assurance (NCQA) and URAC are recognized as accrediting entities by the Secretary of HHS to provide accreditation of QHPs meeting the requirement of this section. Such recognition is effective until rescinded or recognition is required to be made by the process identified in paragraph (c)(1)(ii) of this section.

(ii) [Reserved]

(2)(i) *Scope of accreditation.* Subject to paragraphs (c)(2)(ii) through (iv) of this section, recognized accrediting entities must provide accreditation within the categories identified in paragraphs (a)(1) of this section.

(ii) *Clinical quality measures.* Recognized accrediting entities must include a clinical quality measure set in their accreditation standards for health plans that:

(A) Spans a breadth of conditions and domains, including, but not limited to, preventive care, mental health and substance abuse disorders, chronic care, and acute care.

(B) Includes measures that are applicable to adults and measures that are applicable to children.

(C) Aligns with the priorities of the National Strategy for Quality Improvement in Health Care issued by the Secretary of HHS and submitted to Congress on March 12, 2011;

(D) Only includes measures that are either developed or adopted by a voluntary consensus standards setting body (such as those described in the National Technology and Transfer Advancement of Act of 1995 (NTTAA) and Office of Management and Budget (OMB) Circular A-119 (1998)) or, where appropriate endorsed measures are unavailable, are in common use for health plan quality measurement and meet health plan industry standards; and

(E) Is evidence-based.

(iii) *Level of accreditation.* Recognized accrediting entities must provide accreditation at the Exchange product type level.

(iv) *Network adequacy.* The network adequacy standards for accreditation used by the recognized accrediting entities must, at a minimum, be consistent with the general requirements for network adequacy for QHP issuers codified in § 156.230(a).

(3) *Methodological and scoring criteria for accreditation.* Recognized accrediting entities must use transparent and rigorous methodological and scoring criteria.

(4) *Documentation.* An accrediting entity must provide the following documentation:

(i) To be recognized, an accrediting entity must provide current accreditation standards and requirements, processes, and measure specifications for performance measures to demonstrate that each entity meets the conditions described in paragraphs (c)(2) and (3) of this section to HHS at a time period specified by HHS.

(ii) Recognized accrediting entities must provide any proposed changes or updates to the accreditation standards and requirements, processes, and measure specifications for performance measures with 60 days notice prior to implementation.

(5) *Data sharing requirements between the recognized accrediting entities and Exchanges.* When authorized by an accredited QHP issuer pursuant to paragraph (a)(2) of this section, recognized accrediting entities must provide the following QHP issuer's accreditation survey data elements to the Exchange in which the issuer plans to operate one or more QHPs during the annual certification period or as changes occur to these data throughout the coverage year—the name, address, Health Insurance Oversight System (HIOS) issuer identifier, and unique accreditation identifier(s) of the QHP issuer and its accredited product line(s) and type(s) which have been released; and for each accredited product type:

(i) HIOS product identifier (if applicable);

(ii) Accreditation status, survey type, or level (if applicable);

(iii) Accreditation score;

(iv) Expiration date of accreditation; and

(v) Clinical quality measure results and adult and child CAHPS measure survey results (and corresponding expiration dates of these data) at the level specified by the Exchange.