New York Health Benefit Exchange

Blueprint Summary for
Section 4.0 Plan Management
October 26, 2012

Item Number	Topic
4.4	Ensure Ongoing QHP Compliance

New York has had extensive experience with joint agency regulation of health plans through the Department of Financial Services (formerly the New York Department of Insurance) and the Department of Health. The Exchange will leverage this experience by working collaboratively with one another to ensure ongoing compliance.

Currently, health plans are audited in various ways by the Department of Financial Services and the Department of Health. The Exchange will evaluate these audits in collaboration with the agencies to determine whether and/or how the audits need to be modified to accommodate Exchange requirements and minimize any duplicative efforts. Below is a description of current oversight by the agencies:

- The Department of Health audits managed care plans, including HMOs, Medicaid Managed Care plans, and Child Health plus plans. These audits generally occur every two years and review regulations, including enrollee appeals and complaints, quality improvement related activities, requirements related to members infected with HIV, organizational structures, and provider agreements.

- The Department of Health also audits Child Health Plus enrollment in managed care plans to ensure enforcement of the eligibility regulations. Given that all Child Health Plus enrollment will occur through the Exchange, it is likely that this audit will no longer need to occur for plan years beginning 2014.

- The Department of Health collects quality and consumer satisfaction data from all health plans through the reporting system known as Quality Assurance Reporting Requirements (QARR). This reporting system is comprised of generally two components: (1) access, quality and utilization measures that are largely adopted from the NCQA Healthcare Effectiveness Data and Information Set (HEDIS); and (2) the consumer experience of care survey questions from the Consumer Assessment of Health Care Providers and Systems (CAHPS) survey. There are approximately 60 HEDIS measures and 20 CAHPS measures. There is also a small number of New York State specific measures that are of particular concern to the state (e.g., quality of adolescent

preventive care). The collection of this data will continue and the Exchange will work collaboratively with the Department of Health in keeping track of these measures.

- While not an audit, the Department of Health collects Medicaid Managed Care Operating Reports (MMCOR) data from its Medicaid Managed Care plans. These reports capture utilization data, membership data, and financial data. The Department of Health also collects encounter data from its Medicaid Managed Care plans, which describes demographics and health status of the populations, reports and monitors service utilization, evaluates access and continuity of services issues, monitor and develops quality and performance indicators, sets rates, performs cost effective analysis, and evaluates various service models and environments. These reporting requirements provide meaningful datasets to assist the Department of Health in its oversight role.

- The Department of Financial Services performs market conduct surveys every five years, and has the ability to request information at any time from health plans through its regulatory authority. The market conduct surveys include review of health plan financial solvency, finances in relation to regulations and accounting standards, medical loss ratio, claims payment, and applicable Department of Labor regulations.

In addition to the above, the Exchange has engaged MAXIMUS to handle its customer service function, including complaints, grievances and enrollee appeals. MAXIMUS currently handles these issues on behalf of the Department of Health for the Medicaid and Child Health Plus populations, and these efforts will be expanded to include members enrolled through qualified health plans. MAXIMUS will have a process to monitor health plan performance and to collect, analyze, and resolve enrollee complaints. This process will be facilitated by a complaints module at the Call Center that will include a workflow process for complaints to be captured, analyzed, and referred to the appropriate entity for resolution. Before a complaint is referred to a State entity, a trained specialist will first identify if resolution is within Call Center's control. If the complaint can be resolved before escalation to a State entity such as the Exchange, Department of Financial Services, Department of Health, the specialist will collect relevant information in the complaints module, including the action taken to resolve the complaint. If the complaint cannot be resolved and requires escalation to a State entity, the complaints module contains the workflow functionality to create a referral task for the complaint to be referred to the appropriate State entity for resolution. The complaints module also includes the ability to track, monitor and trend all complaints.