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MINNESOTA MDH DEPARTMENT OF HEALTH

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Legislative Report Recommendations on Minnesota Statutes, Chapter 62K

Accreditation, Quality Assurance and Improvement Standards

Minnesota Department of Health

Report to the Minnesota Legislature 2015

February 2015

Legislative Report Recommendations on Minnesota Statutes, Chapter 62K

Accreditation, Quality Assurance and Improvement Standards

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Executive Summary

Description
Minnesota Statutes, section 62K.12, subdivision 1, directs the Commissioner of Health to make recommendations for specific quality assurance and improvement standards for Minnesota health carriers offering products in the individual and small group market and offering products through MNsure or through the non-MNsure market. This report is submitted to the legislature in accordance with the law.

The report is based upon the experience of the Minnesota Department of Health, Health Regulation Division, Managed Care Systems Section's experience with health plan quality improvement systems, health plan accreditation and HEDIS® measures. Stakeholder comments were requested in the preparation of this report.

Need
The rationale for these recommendations is based upon the changes in federal and state law regarding individual and small group marketplace which apply to new stakeholders with varying experience. Specific standards are needed to ensure equity and efficiency for all Minnesota health carriers while ensuring high-quality affordable health care and improved outcomes for Minnesota consumers.

The objective is to:

- Ensure fair competition for all Minnesota health carriers,
- Avoid duplicative data gathering, analysis or reporting, and
- Promote the provision of high-quality affordable health care and improved outcomes.

Conclusions
Our recommendations would apply to all Minnesota health carriers offering products in the individual and small group market and offering products through MNsure or through the non-MNsure market. MDH is submitting nine recommendations:

<u>Recommendations related to accreditation standards:</u>

1. Proof of accreditation for both on exchange and off exchange health carriers will be submitted through Systems for Electronic Rate and Form Filing (SERFF).
2. In order to be consistent on and off the exchange and provide an opportunity for non-accredited health carriers to become accredited, they will be offered the same accommodations as outlined in Minnesota Statutes, section 62K.09, subdivision 2(a).
3. Exceptions for health carriers due to low volume will apply to health carriers both on and off the exchange.
    - Criteria will be developed by a team consisting of the Department of Commerce, MDH, and MNsure and others as appropriate no later than October 1, 2015. Criteria for "low volume" will apply for health carriers both on and off MNsure

and criteria will be included in the accreditation instructions posted on the MDH website.

- MDH will grant "low volume" exceptions to health carriers not on the exchange based on the designated criteria.
- MNsure, otherwise known as the Minnesota Insurance Marketplace, will grant "low volume" exceptions to health carriers on the exchange based on the designated criteria.

4. Health carriers with low membership volume shall be deemed compliant with the accreditation requirements in 62K through review of policies and procedures only and granted a low volume exception from MNsure (on exchange) or MDH (not on the exchange). This means accredited carriers can be deemed compliant but not fully accredited until or if their membership volume becomes large enough to be assigned a full accredited entity ranking.

Recommendations related to quality assurance and improvement standards:

5. The requirements in Minnesota Department of Health Statutes, section 62K.12, subdivision 1, paragraph (a), clauses (1) – (5) will be carried out by the health carriers until January 1, 2018 for non-MNsure carriers.
6. During the period of non-accreditation on the exchange, (appropriate level of accreditation no later than the third year after the first year the health carrier offers a qualified health plan) the standards contained in Minnesota Statutes, section 62K.12, subdivision 1, paragraph (a), clauses (1) - (5) will be applied.
7. Minnesota Statutes, section 62K.12, subdivision 1, paragraph (a), clause (6) should be changed to read; *health carriers will collect and report HEDIS or URAC measures and conduct quality improvement activities as appropriate and/or as directed by the Commissioner of Health.*
8. Health carriers will post quality measures on their websites to increase transparency and consumer access to quality data.
9. For the protection of consumers, a task force consisting of MDH, the Department of Commerce, MNsure and others as appropriate will be formed and criteria developed to address steps and actions the State will take if a health carrier loses its full accreditation through URAC or loses its NCQA excellent or commendable level ranking.

Purpose

The Patient Protection and Affordable Care Act (ACA) was signed into law March 23, 2010. One of the primary goals of the ACA was to transform the quality of patient care and make healthcare more affordable. The ACA has placed more emphasis on quality assurance and improvement standards prompting health carriers and their contracting provider entities to look towards accreditation and more robust data collecting.

The dominant theme behind healthcare transformation has been to gradually shift providers out of the fee-for-service patterns which promote high cost while not necessarily improving quality, and instead focus on quality cost-effective care. To bolster these efforts providers have increasingly been incentivized by tying provider payments to quality of care measured through data collection. Incorporating more robust data measurements on the part of the health carriers and providers can not only reduce cost, but also protect the consumer by promoting high quality cost-effective care and reducing waste. These standards will help lay the foundation for higher quality healthcare delivery.

In 2013, the Minnesota Legislature passed the *Minnesota Health Plan Market Rules,* Minnesota Statutes, Chapter 62K (the Market Rules). Governor Mark Dayton signed the bill into law May 24, 2013, effective for health plans offered, sold, issued, or renewed in the individual or small group market on or after January 1, 2015, unless otherwise specified. **Due to the Market Rules, by January 1, 2018 all health carriers that offer any individual or small group health plans in Minnesota either outside and/or inside of MNsure will have attained the appropriate level of accreditation** through URAC, the National Committee for Quality Assurance (NCQA), or any entity recognized by the by the United State Department of Health and Human Services for accreditation of health insurance issuers or health plans. (See Minnesota Statutes, section 62K.09, subdivisions 1 and 2)

The accreditation bodies referred to in the Market Rules require comprehensive evaluation of a carrier's systems, processes, and performance to determine whether the carrier meets predetermined specific criteria. (See Appendices i and ii) MDH recognizes accreditation in the following areas: Quality Improvement; Credentialing; Member Protection; and Utilization Management.

The purpose of this report is to comply with Minnesota Statutes, section 62K.12, subdivision 1, which states: *The commissioner of health shall submit a report to the chairs and ranking minority members of senate and house of representatives committees with primary jurisdiction over commerce and health policy by February 15, 2015, with recommendations for specific quality assurance and improvement standards for all Minnesota health carriers. The recommended standards must not require duplicative data gathering, analysis, or reporting by health carriers.*

Because the Market Rules require all carriers that offer any individual or small group health plans in Minnesota whether inside and/or outside of MNsure to be accredited by January 1, 2018, our recommendations will not be inconsistent with accreditation standards. Accrediting organizations such as NCQA or URAC maintain detailed processes and standards in order to attain accreditation and collect data. MDH has historically understood these data collection procedures and standards as the community standard for performance measurement and improvement.

RECOMMENDATIONS

Minnesota Statutes, section 62K.09, subdivision 1, paragraph (a) states as follows:

> A health carrier that offers any individual or small group health plans in Minnesota must be accredited in accordance with this subdivision. A health carrier must obtain accreditation through the Utilization Review Accreditation Commission (URAC, also known as DBA American Accreditation Healthcare), the National Committee for Quality Assurance (NCQA), or any entity recognized by the United States Department of Health and Human Services for accreditation of health insurance issuers or health plans by January 1, 2018. Proof of accreditation must be submitted to the commissioner of health in a form prescribed by the commissioner of health.

Recommendation: Proof of accreditation for both on exchange and off exchange health carriers will be submitted through System for Electronic Rate and Form Filing (SERFF). SERFF is already being used in Minnesota for form and rate filing submissions. (See appendix iii.)

Minnesota Statutes, section 62K.09, subdivision 2, paragraph (a) states as follows:

> MNsure shall require all health carriers offering a qualified health plan through MNsure to obtain the appropriate level of accreditation no later than the third year after the first year the health carrier offers a qualified health plan through MNsure. A health carrier must take the first step of the accreditation process during the first year in which it offers a qualified health plan. A health carrier that offers a qualified health plan on January 1, 2014, must obtain accreditation by the end of the 2016 plan year.

Recommendation: In order to be consistent on and off the exchange and provide an opportunity for non-accredited health carriers off exchange to become accredited, they will be offered the same accommodations as outlined in Minnesota Statutes, section 62K.09, subdivision 2, paragraph (a).

Minnesota Statutes, section 62K.09, subdivision 2, paragraph (b) states as follows:

> To the extent a health carrier cannot obtain accreditation due to low volume of enrollees, an exception to this accreditation criterion may be granted by the Minnesota Insurance Marketplace until such time as the health carrier has a sufficient volume of enrollees.

Recommendation: Exceptions for health carriers due to low volume will apply to health carriers both on and off the exchange.

- Criteria will be developed by a team consisting of Commerce, MDH, and MNsure and others as appropriate no later than October 1, 2015. Criteria for "low volume" will apply for health carriers both on and off MNsure and criteria will be included in the accreditation instructions posted on the MDH website.
- MDH will grant "low volume" exceptions to health carriers not on the exchange based on the designated criteria.
- MNsure, otherwise known as the Minnesota Insurance Marketplace, will grant "low volume" exceptions to health carriers on the exchange based on the designated criteria.

Recommendation: Health carriers with low membership volume shall be deemed compliant with the accreditation requirements in 62K through review of policies and procedures only and granted a low volume exception from MNsure (on exchange) or MDH (not on the exchange). This means accredited carriers can be deemed compliant but not fully accredited until or if their membership volume becomes large enough to be assigned a full accredited entity ranking.

Minnesota Statutes, section 62K.12, subdivision 1, paragraph (a), clauses (1) – (6) states as follows:

> All health carriers offering an individual health plan or small group health plan must have a written internal quality assurance and improvement program that, at a minimum:
>
> (1) provides for ongoing evaluation of the quality of health care provided to its enrollees;
>
> (2) periodically reports the evaluation of the quality of health care to the health carrier's governing body;
>
> (3) follows policies and procedures for the selection and credentialing of network providers that is consistent with community standards;
>
> (4) conducts focused studies directed at problems, potential problems, or areas with potential for improvements in care;
>
> (5) conducts enrollee satisfaction surveys and monitors oral and written complaints submitted by enrollees or members; and
>
> (6) collects and reports Healthcare Effectiveness Data and Information Set (HEDIS) measures and conducts other quality assessment and improvement activities as directed by the commissioner of health.

Recommendation: Minnesota Statutes, section 62K.12, subdivision 1, paragraph (a), clauses (1) – (5) will apply to health carriers off exchange until January 1, 2018.

Recommendation: Minnesota Statutes, section 62K.12, subdivision 1, paragraph (a), clauses (1) – (5) will apply to health carriers on exchange if there is a period of time when a health carrier is not accredited (appropriate level of accreditation must be obtained no later than the third year after the first year the health carrier offers a qualified health plan)

Recommendation: Minnesota Statutes, section 62K.12, subdivision 1, paragraph (a), clause (6) should be changed to read: *health carriers will collect and report HEDIS or URAC measures and conduct quality improvement activities as appropriate and/or as directed by the Commissioner of Health.* (See Appendix vi)

Recommendation: health carriers will post quality measures on their own websites to increase transparency and consumer access to quality data.

Minnesota Statutes, section 62K.12, subdivision 3 states as follows:

> A health carrier that has obtained accreditation through the URAC for network management; quality improvement; credentialing; member protection; and utilization management, or has achieved an excellent or commendable level ranking from the National Committee for Quality Assurance (NCQA), shall be deemed to meet the requirements of subdivision 1. Proof of accreditation must be submitted to the commissioner of health in a form prescribed by the commissioner.

Recommendation: For the protection of consumers, a task force consisting of MDH, the Department of Commerce, MNsure, and others as appropriate will be formed and criteria developed to address steps and actions the State will take if a health carrier loses its full accreditation through URAC or loses its NCQA excellent or commendable level ranking.

Appendix i

What is NCQA? – National Committee for Quality Assurance

The National Committee for Quality Assurance is a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality.

The NCQA seal is a widely recognized symbol of quality. Organizations incorporating the seal into advertising and marketing materials must first pass a rigorous, comprehensive review and must annually report on their performance. For consumers and employers, the seal is a indicator that an organization is well-managed and delivers high quality care and service.

NCQA's programs and services reflect a straightforward formula for improvement: Measure. Analyze. Improve. Repeat. NCQA makes this process possible in health care by developing quality standards and performance measures for a broad range of health care entities. These measures and standards are the tools that organizations and individuals can use to identify opportunities for improvement.

These plans cover 117 million Americans or 70.5 percent of all Americans enrolled in health plans.

HEDIS (Healthcare Employer Data and Information Set) is a NCQA tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Because so many plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis. Health plans also use HEDIS results themselves to see where they need to focus their improvement efforts.

Source: www.ncqa.org

Appendix ii:

What is URAC? – Utilization Review Accreditation Commission (also known as American Accreditation Healthcare)

URAC, an independent, nonprofit organization, offers a wide range of quality benchmarking programs and services that model the rapid changes in the healthcare system. Through its broad-based governance structure and an inclusive standards development process, URAC ensures that all stakeholders are represented in establishing meaningful quality measures for the entire healthcare industry.

URAC standards are developed by a committee of experts representing diverse interests in the health care community: providers, health care organizations, insurers, and the public interest. When new standards are developed, experts from that particular area of health care delivery participate on the committee. URAC always circulates draft standards for public comment so that anyone can have input in the standards development process.

URAC adopted the US Department of Health and Human Services National Quality Priorities that were published in March 2011.

Source: www.urac.org

Appendix iii:

What is SERFF?

System for Electronic Rate and Form Filing (SERFF) is an internet application designed to provide an efficient process for rate and form filing for health carriers. Filings are created and submitted at a centralized database located at the National Association of Insurance Commissioners (NAIC). Filings are routed to the appropriate state business area depending on the product being filed.

Source: www.serff.com

Appendix iv:

Table of health carriers and Accreditation Status – On MNsure Exchange

2014 Carriers Offering Individual and Small Group on the MNsure Exchange in 2015

Plan Name	Type	Accreditation
Blue Cross Blue Shield of Minnesota	Individual and Small Group	NCQA-Commendable
Blue Plus (HMO)	Individual and Small Group	NCQA-Commendable
HealthPartners, Inc.	Individual	NCQA-Excellent
Medica Health Plan	Individual and Small Group	NCQA-Accredited
UCare Minnesota (HMO)	Individual	NCQA-Accredited

*Enrollment data for MNsure will not be made public until February of 2015

Table of health carriers and Accreditation Status – Off Exchange

CY2013^ Enrollment of Carriers Offering Individual and Small Group off the MNsure Exchange in 2015

Plan Name	Type	Accreditation	CY2013 Enrollment	Proportion
Blue Cross and Blue Shield of Minnesota	Individual and Small Group	NCQA-Commendable	258,825	45.5%
Blue Plus (HMO)	Small Group	NCQA-Commendable	5	0.0%
Federated	Small group	Exempt	7,886	1.4%
HealthPartners	Individual and Small Group	NCQA-Excellent	88,494	15.6%
HealthPartners Insurance Company	Individual and Small Group	NCQA-Excellent	43,210	7.6%
John Alden Life Insurance Company	Individual and Small Group	URAC-Full Accreditation	1,001	0.2%
Medica	Individual	NCQA-Excellent	432	0.1%
Medica Insurance Company	Individual and Small Group	NCQA-Excellent	116,281	20.5%
PreferredOne Community Health Plan	Small Group	NCQA-Commendable	10,512	1.8%
PreferredOne Insurance Company	Individual and Small Group	*	27,231	4.8%
Sanford	Small group	NCQA-Commendable	711	0.1%
Time Insurance Company	Individual and Small Group	URAC-Full Accreditation	13,649	2.4%
			568,237	**100.0%**

^CY2014 Enrollment not yet available

*NCQA: MDH accepts NCQA accreditation applied to all of the carrier's products.

Source: http://mn.gov/commerce/insurance/images/LossRatioReport.pdf

Appendix v

HEDIS Data Collection for HMOs 2014

The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by health plans to measure performance on dimensions of care and service. Since the measures are specifically defined it makes it possible to compare performance between health plans. Employers and consumers use HEDIS data to help them select the best health plan for their needs. Health plans use HEDIS data to make improvements in their quality activities.

Pursuant to the contract between NCQA and MDH, NCQA provides an extract and validated HEDIS data files for each Health Maintenance Organization (HMO) and County-Based Purchaser (CBP) in Minnesota according to the state's specifications for product lines and measures for which data is to be collected. MDH posts the HEDIS data for HMOs on its website.

The following grids (Table A and B) demonstrate the data currently collected by MDH for the eight HMOs and three County Based purchasers. Table A outlines the Minnesota Department of Health's HEDIS® 2014 Grid for HMOs which identifies the reporting entities and product lines for HEDIS 2014 for measurement year 2013. Table B below specifies the specific HEDIS® measures NCQA will collect from the Minnesota HMOs (as specified in Table A) for each product line.

HEDIS® 2014 GRID Minnesota Department of Health
Minnesota Reporting Entities and Product Lines for HEDIS 2014 for Measurement Year 2013

NCQA collects, cleans and forwards data to MDH from the eight HMOs and three County based Purchasers for the product lines as indicated by the Xs in Table A below. See page 17 for special instructions.

Table A

Reporting Entities	Commercial	Medicare Advantage	Minnesota Health Care Programs-Managed Care/MA	Minnesota Health Care Programs-Managed Care/MNCare	Minnesota Special Needs Plans (M-SNPs)		
			MA Expansion/ Families and Children-MA	Minnesota Care	MSHO 65+	SNBC 18-64	
						SNP	Non-SNP
Blue Plus	X		X	X	X		
Gundersen Health Plan	X	X					
HealthPartners and Group Health	X		X	X	X		
Itasca Medical Care (CBP)			X	X	X		
Medica Health Plans	X		X	X	X		X
Metropolitan Health Plan			X (Hennepin Health MA Expansion Only)		X	X	X
PreferredOne Community Health Plan	X						
PrimeWest Health System (CBP)			X	X	X	X	X
Sanford Health Plan	X						
South Country Health Alliance (CBP)			X	X	X	X	X
UCare		X	X	X	X		X

Special Instructions:

- **All Health Plans**
  - Plans that initiated new products should follow the continuous enrollment criteria for each measure as noted in NCQA's HEDIS 2014 Volume 2: Technical Specifications for Health Plans (HEDIS 2014).

- **Commercial**
  - Health plans may combine commercial fully-insured and self-insured product lines for HEDIS reporting to the state. Follow the NCQA definition for commercial members in HEDIS 2014.
  - Health plans should follow NCQA's HEDIS 2014 rotation measure criteria.
  - Health plans must report to the State those measures indicated in Table B.

- **Medicare Advantage**
  - Health plans should report the measures listed in the CMS memo, *"Updated Requirements for Reporting of 2014 HEDIS®, HOS, and CAHPS® Measures"* dated August 2, 2014 to CMS. Medicare Advantage plans must report to the State those measures indicated in Table B.

- **MHCP – MC**
  - Plans must report to the State those measures indicated in Table B; note that there are mandatory hybrid measures.
  - HEDIS 2014 hybrid measures reported for Families and Children/MA (includes Mecaid Expansion), Minnesota Care, and MHP/Hennepin Health.
    - Hybrid measures are not eligible for HEDIS measure rotation.
    - MA Expansion population will be included with the Families and Children reporting
    - Separate reporting of administrative and hybrid measures for F&C-MA and Minnesota Care is required rather than aggregate all MHCP products as done in previous years. (Indicated in Table A).
    - Utilize all HEDIS 2014 Technical Specification Optional Exclusions for the MHCP-MC hybrid measures.
    - Sampling methods based on the prior year's reported rate will not be used for reporting of hybrid measures.

- **Minnesota Special Needs Plans (M-SNPs)**

  SNP plans typically will be required to submit two submissions to NCQA for the different agency reporting requirements: 1) CMS and 2) State of Minnesota (**M-SNPs**). When submitting SNP data, plans should work with its auditors and NCQA to assure that the required data are included in both CMS and the State of Minnesota (**M-SNPs**) submissions. M-SNPs must report to the State those measures indicated in Table B.
  - SNBC
    - Minnesota Special Needs Plans for reporting M-SNP products to MDH*, the SNBC population should include:
      - For SNP plans with both dual and non-dual eligibility and where for the members with dual eligibility the plan is responsible for and has claims for both Medicare and Medicaid, submit data for all these members, both dual and non-duals. (SNBC SNP)
      - For SNP plans with both dual and non-dual eligibility and where for the members with dual eligibility the plan is responsible for and has claims

for only the Medicaid portion and Medicare is handled elsewhere, report on the non-duals only (Medicaid only enrollees). (SNBC Non-SNP)

- SNBC plans will report separately for SNBC SNP and SNBC Non-SNP.
- SNBC must report to the State those measures indicated in Table B; note that there are mandatory hybrid measures.
- HEDIS 2014 hybrid measures reported for SNBC.
    - Hybrid measures are not eligible for HEDIS measure rotation.
    - Utilize all HEDIS 2014 Technical Specification Optional Exclusions for the SNBC hybrid measures.
    - Sampling methods based on the prior year's reported rate will not be used for reporting of hybrid measures.

- **MSC+**
    - No submission is required for MSC+.

HEDIS® 2014 Measures to be Submitted to NCQA for Measurement Year 2013 by Product Line

Table B

Identifier	HEDIS® Measures	Commercial	Medicare Advantage	MHCP-MC	MHCP - MC	M-SNPs	
				MA Expansion/ Families and Children-MA	Minnesota Care	MSHO	SNBC
	Effectiveness of Care						
	Prevention and Screening						
ABA	Adult BMI Assessment	X	X	XH	XH		XH
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	X		X	X		
CIS	Childhood Immunization Status	X		XH	XH		
IMA	Immunizations for Adolescents	X		XH	XH		
HPV	Human Papillomavirus Vaccine for Female Adolescents	X		XH	XH		
BCS	Breast Cancer Screening	X	X	X	X	X	X
CCS	Cervical Cancer Screening	X		XH	XH		XH
COL	Colorectal Cancer Screening	X	X			X	X
CHL	Chlamydia Screening in Women	X		X	X		
GSO	Glaucoma Screening in Older Adults		X			X	
COA	Care for Older Adults (SNP only measure)					X	

	Respiratory Conditions						
PCE	Pharmacotherapy Management of COPD Exacerbation		X			X	X
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD		X			X	X
ASM	Use of Appropriate Medications for People with Asthma	X		X	X		
	Cardiovascular Conditions						
CMC	Cholesterol Management for Patients with Cardiovascular Conditions	X	X	XH	XH		XH
CBP	**Controlling High Blood Pressure	X	X	XH	XH	X	XH
PBH	Persistence of Beta Blocker Treatment After Heart Attack	X	X	X	X	X	X
	Diabetes						
CDC	Comprehensive Diabetes Care	X	X	XH	XH	X	XH
	Musculoskeletal Conditions						
ART	Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis		X				
OMW	Osteoporosis Management in Women Who had a Fracture		X			X	
	Behavioral Health						
AMM	Antidepressant Medication Management	X	X	X	X	X	X

ADD	Follow-up care for Children prescribed ADHD Medication	X		X	X		
FUH	Follow-up After Hospitalization for Mental Illness		X			X	X
	Medication Management						
MPM	Annual Monitoring for Patients on Persistent Medications	X	X	X	X	X	X
MRP	Medication Reconciliation Post Discharge (SNP only)					X	
DDE	Potentially Harmful Drug-Disease Interactions in the Elderly		X			X	
DAE	Use of High Risk Medications in the Elderly		X			X	
	Access/Availability of Care						
AAP	Adults' Access to Preventive/Ambulatory Health Services	X	X	X	X	X	X
CAP	Children's and Adolescents' Access to Primary Care Practitioners	X		X	X		
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	X	X	X	X	X	X
PPC	**Prenatal and Postpartum Care	X		XH	XH		
	Utilization						
W15	Well-child Visits in the first 15 months of life	X		XH	XH		
W34	Well-child visits in the 3rd, 4th, 5th, and 6th years of life	X		XH	XH		

AWC	Adolescent Well-child care visits	X		XH	XH		
AMB	Ambulatory Care	X	X	X	X	X	X
IPU	Inpatient Utilization-General hospital/acute care	X	X	X	X	X	X
IAD	Identification of Alcohol and Other Drug Services	X	X	X	X	X	X
MPT	Mental Health Utilization	X	X	X	X	X	X
PCR	Plan All–Cause Readmissions		X			X	X
	Health Plan Descriptive Information						
BCR	Board Certification					X	X
ENP	Enrollment by Product Line	X	X	X	X	X	X

XH indicates these measures must utilize hybrid methodology for the MHCP-MC products of Families and Children-MA (includes Medicaid Expansion) , Minnesota Care, and SNBC.

** These measures are eligible for rotation in 2014 for Commercial plans that had an audited and reportable rate from the previous year using the hybrid method. MHCP-MC hybrid measures are not eligible for rotation.

Changes in 2014

- The Lead Screening Measure will no longer be collected by MDH. Lead is monitored by the Environmental Health Division.
- The Human Papillomavirus Vaccine for Adolescent Females measure was added for the Commercial and the MHCP-MC products of F&C-MA and Minnesota Care.
- In order to be consistent with DHS's contractual requirements (refer to DHS Contract Sections 7.2 F&C, 7.15 SNBC, 7.12 Hennepin Health, 7.7 MSHO) and be less burdensome to the Plans, MDH will require the Plans to report separately for F&C-MA and Minnesota Care.
    - Eliminates the burden of having to report separately for DHS and aggregate for MDH.
    - Allows for improved analysis of MHCP-MC products given different benefits, different utilization of services, different number of enrollees and race/ethnicity differences.
- The following are mandatory hybrid method measures for F&C-MA and Minnesota Care:
    - Adult BMI Assessment

  - Childhood Immunization Status
  - Immunizations for Adolescents
  - Human Papillomavirus Vaccine for Adolescent Females
  - Cervical Cancer Screening
  - Cholesterol Management for Patients with Cardiovascular Conditions
  - Controlling High Blood Pressure
  - Comprehensive Diabetes Care
  - Prenatal and Postpartum Care
  - Well Child Visits in the First 15 Months of Life
  - Well Child Visits in the 3rd,4th,5th, and 6th Years of Life
  - Adolescent Well Child Visits
- The following are mandatory hybrid method measures for SNBC:
  - Adult BMI Assessment
  - Cervical Cancer Screening
  - Cholesterol Management for Patients with Cardiovascular Conditions
  - Controlling High Blood Pressure
  - Comprehensive Diabetes Care
- The following are mandatory hybrid method measures for Hennepin Health:
  - Adult BMI Assessment
  - Cervical Cancer Screening
  - Cholesterol Management for Patients with Cardiovascular Conditions
  - Controlling High Blood Pressure
  - Comprehensive Diabetes Care

Appendix vi

Applicable Minnesota Statutes 62K. 02, 62K.09 and 62K.12

62K.02 PURPOSE AND SCOPE.
Subdivision 1.

Purpose. The market rules set forth in this chapter serve to clarify and provide guidance on the application of state law and certain requirements of the Affordable Care Act on all health carriers offering health plans in Minnesota, whether or not through MNsure, to ensure fair competition for all health carriers in Minnesota, to minimize adverse selection, and to ensure that health plans are offered in a manner that protects consumers and promotes the provision of high-quality affordable health care, and improved health outcomes.

Subd. 2.

Scope. (a) This chapter applies only to health plans offered in the individual market or the small group market.

(b) This chapter applies to health carriers with respect to individual health plans and small group health plans, unless otherwise specified.

* * *

62K.09 ACCREDITATION STANDARDS.
Subdivision 1.

Accreditation; general. (a) A health carrier that offers any individual or small group health plans in Minnesota outside of the Minnesota Insurance Marketplace must be accredited in accordance with this subdivision. A health carrier must obtain accreditation through URAC, the National Committee for Quality Assurance (NCQA), or any entity recognized by the United States Department of Health and Human Services for accreditation of health insurance issuers or health plans by January 1, 2018. Proof of accreditation must be submitted to the commissioner of health in a form prescribed by the commissioner of health.

(b) A health carrier that rents a provider network is exempt from this subdivision, unless it is part of a holding company as defined in section 60D.15 that in aggregate exceeds ten percent market share in either the individual or small group market in Minnesota.

Subd. 2.

Accreditation; Minnesota Insurance Marketplace. (a) The Minnesota Insurance Marketplace shall require all health carriers offering a qualified health plan through the Minnesota Insurance Marketplace to obtain the appropriate level of accreditation no later than the third year after the first year the health carrier offers a qualified health plan through the Minnesota Insurance Marketplace. A health carrier must take the first step of the accreditation process during the first year in which it offers a qualified health plan. A health carrier that offers a qualified health plan on January 1, 2014, must obtain accreditation by the end of the 2016 plan year.

(b) To the extent a health carrier cannot obtain accreditation due to low volume of enrollees, an exception to this accreditation criterion may be granted by the Minnesota Insurance Marketplace until such time as the health carrier has a sufficient volume of enrollees.

Subd. 3.

Oversight. A health carrier shall comply with a request from the commissioner of health to confirm accreditation or progress toward accreditation.

Subd. 4.

Enforcement. The commissioner of health shall enforce this section.

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62K.12 QUALITY ASSURANCE AND IMPROVEMENT.

Subdivision 1.

General. (a) All health carriers offering an individual health plan or small group health plan must have a written internal quality assurance and improvement program that, at a minimum:

(1) provides for ongoing evaluation of the quality of health care provided to its enrollees;
(2) periodically reports the evaluation of the quality of health care to the health carrier's governing body;
(3) follows policies and procedures for the selection and credentialing of network providers that is consistent with community standards;
(4) conducts focused studies directed at problems, potential problems, or areas with potential for improvements in care;
(5) conducts enrollee satisfaction surveys and monitors oral and written complaints submitted by enrollees or members; and
(6) collects and reports Healthcare Effectiveness Data and Information Set (HEDIS) measures and conducts other quality assessment and improvement activities as directed by the commissioner of health.

(b) The commissioner of health shall submit a report to the chairs and ranking minority members of senate and house of representatives committees with primary jurisdiction over commerce and health policy by February 15, 2015, with recommendations for specific quality assurance and improvement standards for all Minnesota health carriers. The recommended standards must not require duplicative data gathering, analysis, or reporting by health carriers. [Emphasis added]

Subd. 2.

Exemption. A health carrier that rents a provider network is exempt from this section, unless it is part of a holding company as defined in section 60D.15 that in aggregate exceeds ten percent market share in either the individual or small group market in Minnesota.

Subd. 3.

Waiver. A health carrier that has obtained accreditation through the URAC for network management; quality improvement; credentialing; member protection; and utilization

management, or has achieved an excellent or commendable level ranking from the National Committee for Quality Assurance (NCQA), shall be deemed to meet the requirements of subdivision 1. Proof of accreditation must be submitted to the commissioner of health in a form prescribed by the commissioner. The commissioner may adopt rules to recognize similar accreditation standards from any entity recognized by the United States Department of Health and Human Services for accreditation of health insurance issuers or health plans.

Subd. 4.

Enforcement. The commissioner of health shall enforce this section.

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Minnesota Statutes, Chapter 62K, applies to health carriers as defined in Minnesota Statutes, section 62A.011, subdivision 2, below:

62A.011 DEFINITIONS.
Subdivision 2.

Health carrier. "Health carrier" means an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a nonprofit health service plan corporation operating under chapter 62C; a health maintenance organization operating under chapter 62D; a fraternal benefit society operating under chapter 64B; or a joint self-insurance employee health plan operating under chapter 62H.

At the present time, this provision includes insurance companies, Blue Cross/Blue Shield of MN, and health maintenance organizations (HMOs). Some health carriers may offer both insurance and HMO plans. In Minnesota, insurance companies and nonprofit health service plan corporations are regulated by the MN Department of Commerce. HMOs are regulated by the Minnesota Department of Health. For purposes of Minnesota Statutes, Chapter 62K, the Minnesota Department of Commerce and the Minnesota Department of Health collaborate to regulate the health carriers.

In addition, Minnesota Statutes, Chapter 62K, applies to health plans that offer policies in small group and individual markets, whether the carrier offers coverage on the state-operated health insurance exchange, MNsure, or off MNsure.

Subd. 2.
(a) This chapter applies only to health plans offered in the individual market or the small group market.

(b) This chapter applies to health carriers with respect to individual health plans and small group health plans, unless otherwise specified.

Small group is defined as a health plan issued by a health carrier to a small employer as defined in section 62L.02, subdivision 26, or generally a small employer engaged in business in

Minnesota that employed an average of at least one, not including a sole proprietor, but not more than 50 current employees.

Individual health plan means an individual health plan as defined in Minnesota Statutes, section 62A.011, subdivision 4, or generally, a plan offered in the individual market to individuals other than in connection with a group plan.