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Print
Page 19
Page 20
Page 21
Page 22
Page 23
Page 24
Page 25
Page 26
Page 27
Page 28
Page 29
Page 30
Page 31
Page 32
Page 33
Page 34
Page 35
Page 36
Page 37
Page 38
Page

licensing and oversight requirements and not for accreditation of health plans. However, the statute requires the QHP issuer to be accredited and have the Secretary's approval accepting accreditation, in order for the plan to be considered a qualified health plan. Because the statutory requirements for accreditation are not the same as the requirements for accreditation, we will consider the role of entities that perform this function in providing accreditation.

Comment: One commenter expressed a specific preference for URAC to be chosen AND approved as a recognized accrediting entity so that QHPs may participate in the Exchange and SHOP Exchange. Another commenter stated that it presents misunderstanding. The commenter suggested that CMS/HHS does not need to approve of being a recognized accrediting entity for a specified timeline, that CMS/HHS should not approve of any specific accreditation standard and that standards are available.

Response: As noted, we have made a technical correction to the proposed rule to accurately state that URAC has been renamed to Health Plan Accreditation Program Version 1 which includes reporting on CAHPS survey and a set of quality measures. We agree that URAC's Health Plan Accreditation Program is a recognized accrediting entity. Accreditation plans are recognized as process since both entities fulfill the documentation requirements finalized at § 156.275(b).

Comment: One commenter requested clarification regarding which health plan accreditation standards would be considered equivalent to the Exchange quality enhancement standards. Some commenters suggested that the Accreditation Exchange Version 1.0 and successor Version 2.0.

Response: We clarify that URAC's Quality enhanced Health Plan Accreditation Program Version 1 includes the standards that meet the statutory requirements for accreditation, as accrediting entities will offer and have been offered since January 1, 2011.

Comment: Several commenters expressed concern that NCQA or URAC accreditation is not the best measure of quality. Other commenters stated that Consumer Operated and Oriented Plans (CO-OP). The commenters are concerned that the requirement for accreditation within 18 months of the adoption/ addition/ renewal of the first qualified HIT/EHR certified for the Affordable Care Act, including member control, consumer focus and benefit design, quality improvement, and health care delivery system reform. Other stated that accreditation process is lacking a focus on the unique nature of CO-OPs.

Response: Pursuant to §1311(h) and §1301(a)(1)(B) we stated the same accreditation standards as other QHPs. We maintain, in this final rule, the recognition of accrediting entities for plans only. We will consider the unique nature of CO-OPs when we develop the standards for as we develop the requirements for the plans to participate.

2. PHASED RECOGNITION PROCESS FOR ACCREDITION ENTITIES & PRI PROCESS

We proposed that the recognition or an approved entity for accreditation of QHPs would be phased in over a period of time. Accreditation would be required for the process that we intend to identify in future rulemaking. We proposed for the future plan/ issuer recognition process to include an application process, a review process, a process for ongoing monitoring, a process for public participation, and public reporting. We recognized the conflict between licensing/ recognition and accrediting entities. We proposed to address this issue in future rulemaking.

Comment: A few commenters stated that recognized accrediting entities' accreditation processes should be equally rigorous, include comparable accreditation standards and use consistent standards. One commenter suggested that the process should be phased in over a period of time to allow accreditation to meet these standards with the plans or accrediting entities conducted in recognition there or accrediting entities for the purposes of QHP accreditation.

Response: We agree that recognized accrediting entities should have rigorous, comparable processes and standards. We will consider the commenter's suggestion that the process be phased in over a period of time to allow recognized accrediting entity meet the standards for the plans to participate in process. We will be establishing these standards in future rulemaking and will include the phase out process modified at § 156.275(c).

Comment: One commenter requested clarification and public transparency of a process for plans to be recognized by the Exchange and for accreditation entities. The commenter questioned whether the proposed phase-out of plan right the phased approach also being phased in for new quality reporting and display of QHP information. The commenter suggested that CMS/HHS should use Medicare survey Exchange for reporting accreditation of QHP survey.

Response: We intend to establish through future rulemaking the recognition process of accrediting entities or plan with the standards and other quality reporting requirements, including establishing a quality rating system. We intend to establish standards for accreditation of QHP and for accreditation quality reporting and national benchmarks as process. We will consider commenter's recommendation regarding the phase-in recognition process as we develop future rulemaking.

Comment: One commenter requested clarification that the recognized accreditation process would be a process that would be a phased-in accreditation process proposed to phase-out rather than be grandfathered into phase-in recognition.

Response: As we stated in the proposed rule, we maintain that the recognition of accrediting entities in phase one is effective until it is rescinded or this section is modified or revoked. We will consider the role of the PRI process in the phase-out recognized accrediting entities. We intend to establish standards for recognized for the phase-out recognition process that we intend to identify in future rulemaking. We will consider the commenter's suggestion that the accreditation process is defined. Only a URAC based entity is recognized for the purposes of QHP certification and this accreditation required, regardless of the process. We will consider the role of the PRI process in the phase-out recognition process.

Comment: A few commenters requested HHS to clearly distinguish the broader quality requirements on Exchanges and health insurance issuers and stated that accreditation should not be considered a permanent substitute for such requirements.

Response: We acknowledge that accreditation is not a substitute for the broader quality requirements included in the Affordable Care Act. We intend to use rulemaking and solicitous future public comment and stakeholder input.

Comment: One commenter recommended that HHS monitor how the accrediting entities change and to periodically place a limit on that they may not be included in the marketed one-time (ABA) calculation. The commenter recommended that the criteria for review in the phase-two recognition process for accrediting entities include full transparency in pricing.

Response: Accreditation must have part of the quality improvement strategy for QHP issuers. We will consider the role of the PRI process when will apply to meet the standards that we will be looking for the phase-two recognition process for accrediting entities, increasing competition.

3. CLINICAL QUALITY MEASURE STANDARDS (§156.275(b)(2))

We proposed that the first condition of recognition is based on section 1311(c)(1) of the Affordable Care Act and 1311(h)(1)(B) and 1301(a)(1)(B) and 1311(c)(1) performance in data categories, which are codified at § 156.275(b)(2) and (3):

- Clinical quality measures such as the Healthcare Effectiveness Data and Information Set (HEDIS);
- Patient experience ratings as a standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS);
- Consumer access;
- Utilization management;
- Quality improvement;
- Provider credentialing;
- Complaints and appeals;
- Network adequacy and access; and
- Patient information propriety.

We proposed in § 156.275(b)(3)(i) that the clinical quality measures such actions would be the Healthcare Effectiveness Data and Information Set (HEDIS) and/or qualified QHP of the Affordable Care Act and § 1311(h) and (1)(B)(iii). These criteria were chosen based on stakeholder input and to ensure that the Exchange and health insurance issuer's accreditation are aligned with the Exchange enrollee population.

We proposed that the clinical quality measures set must:

- Have a benefit of conditions and diseases, including, but not limited to, chronic illness, that are most prevalent in the Exchange population and have a high impact;
- Include measures that are applicable to adults and pediatric measures that are applicable to children;
- Include the Agency for Healthcare Research and Quality Improvement in Healthcare measures for the Elements and established by Congress, as listed in 2011 data;
- Include the Centers for Medicare and Medicaid Services Quality Measures for HHS and the Health and Human Services Secretary's Priority Measures (http://www.healthcare.gov/news/factsheets/exchange/national-quality-measures.html);
- Only include measures that are different than those required by the Centers for Medicare and Medicaid Services Quality Measures for Medicare Advantage and Prescription Drug Plans and Medicaid Managed Care Plans, if the measures are not in conflict with the Medicare Advantage and Prescription Drug Plans and Medicaid Managed Care Plans and are appropriate and national measures are unavailable or are not available for health plans quality measurement and meet health plans' industry standards; and
- Be evidence-based.

We solicited comments on these standards for clinical quality measures, including whether additional standards for such measures should be included, the standards for rating individual and non-endorsed measures, and whether HHS should require accreditation entities to require health plans to report a specific clinical measures as part of accreditation and if so, which ones.

Comment: One commenter recommended additional criteria for clinical quality measures to include domains such as outcomes and process quality of care, patient and patient satisfaction, be risk adjusted when appropriate, be scientifically sound, be feasible to implement, be meaningful to consumers and purchasers. One commenters recommended prioritizing measures that are being used consistently by public and private sector purchasers and payers. Commenters recommended that the Exchange should include measures that address the prevention including medication prescribing practices, immunization rates, screening services and health plans efforts to reduce health care disparities and to provide culturally competent services.

Response: Much of the recommended criteria for clinical quality measures are consistent with the standards we proposed. We will consider the criteria for accrediting entities being recognized in the interim phase one. We find that, we are maintaining the standards that we proposed for clinical quality measure set. We will consider the recommended criteria for future rulemaking in phase two.

Comment: Several commenters expressed concern that clinical quality measure standard used by current accrediting entities and the CAHPS survey process do not include people with disabilities. Several commenters recommended that HHS should require accreditation entities to include measures that specifically should include standards for clinical quality measures that address the needs of people with disabilities and that specifically address process in need of improvement. Other commenters recommended that HHS should require that the accreditation process should address healthcare and rehabilitation critical quality measures, the evaluation of quality of life beyond that represented by the typical quality healthcare and network adequacy.

Response: As part of future rulemaking in the phase two recognition process, we will consider these standards.

Comment: One commenter requested clarification regarding which CAHPS survey would be used for the purposes of accreditation, and whether the CAHPS survey will be developed. The commenter expressed the view of preference that the CAHPS Hospital Care Survey and the Christian Group CAHPS as proposed measures tools and recommended if plans or providers such as advanced practice registered nurses and certified registered nurse anesthetists in the Exchange are recommended to be adequately capture the patient and caregiver experiences.

Response: We are finalizing the requirement that the recognized accrediting entities require accreditation to find participation in a patient experience survey as a standardized CAHPS survey. We are not specifying which CAHPS survey is to be used. We intend to establish through future rulemaking standards to ensure that the recognized accrediting entities will use the appropriate CAHPS survey and will use the original core and/or Clinician/Group CAHPS surveys.

Comment: Several commenters expressed support that accreditation include, in the phase two recognition process, the Agency for Healthcare Research and Quality's recognized consumer materials setting forth a. A few commenters stated that measures should be based on national standards such as National Quality Forum (NQF) and National Committee for Quality Assurance (NCQA) and that the language related to measures that are developed or adopted by a consumer consensus standards setting body. This commenter recommended that CMS/ HHS should require that the Exchange quality measures and reporting standards are authorized by the entity with a contract with the Secretary, which is currently with the National Quality Forum (NQF).

Response: We agree that NQF plays a significant role in endorsing quality measures. However, we do not require clinical quality measures to reflect or be endorsed by NQF. We will consider the role of the recognized accrediting entities may use alternate measurement set. We maintain the criteria we proposed for the clinical quality measure set. We will consider the commenter's suggestion that the Secretary's measurement standards as part of the future rulemaking in phase two.

Comment: One commenter suggested that the clinical quality measures requirements be recognized accrediting entities include measures that address patients' and families' perspectives and measures that advance primary care services and medical homes.

Response: We believe that the patient perspective is captured by the requirement that accreditation entities include measures that address patient experience of care survey as (§156.275 (a)(2)). We also maintain in the final rule that clinical quality measures be aligned with priorities of the National Strategy for Quality Improvement in Healthcare (NSQIHC). The NSQIHC's priorities include patient-centered care, process improvement, population health improvement and strengthening primary care using models such as patient-centered medical homes.

Comment: A few commenters recommended requiring independent auditing of results as an additional clinical quality measures considered as part of recertification to ensure the accuracy and comparability of results, to provide a level of confidence being by plans, and to build support among stakeholders.

Response: While independent auditing of results could be an effective way to ensure accuracy and to provide a level of confidence and stakeholders to measures and stakeholders, we maintain in the final rule the criteria we proposed in § 156.275(b)(2), which, we have found to be a feasible approach.

Comment: One commenter suggested that the plans' non-integrated process be based on national standards such as National Quality Forum (NQF) and National Committee for Quality Assurance (NCQA) and that the language related to measures that are developed or adopted by a consumer consensus standards setting body. This commenter recommended that CMS/ HHS should require that the Exchange quality measures and reporting standards are authorized by the entity with a contract with the Secretary, which is currently with the National Quality Forum (NQF).

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Comment: A few commenters suggested requiring accreditation at the Exchange level, rather than at the plan level, to avoid duplicative reporting of clinical quality measures and potential challenges of meaningful comparisons of quality and accreditation means to meet consumer needs. Several commenters expressed concern that the proposed rule does not provide sufficient information on quality and transparency. One commenter recommended that states should have the responsibility to obtain the product level reporting accreditation because it would be duplicative for plans to report to multiple entities. The commenter also requested further clarification and accreditation requirements for insurance providers.

Response: We maintain in the final rule that recognized accrediting entities provide separate accreditation determinations for each Exchange product/plan since QHP issuers must be accredited on the basis of local performance per § 156.275(a). We believe that accreditation at the product level is important because it is the most appropriate level for QHP issuers to be accredited on the basis of local performance. We believe that accreditation at the plan or issuer level would also be unreasonable because of the significant variation across the entities performance data reporting.

Comment: One commenter stated that although NCQA generally accepts by product type, which certifies products Gold, Silver, Commercial, Medicaid, Medicare, Medicaid Managed Care, Medicare Advantage, PPO, HMO, in some exceptions. For example, with NCQA approval, Silver can combine HMO and PPO or POS and PPO for all dental products for HMOD reporting purposes or Medicaid Managed Care Medicaid Managed Care combines data for mandatory and voluntary and Medicaid combined.

Response: We understand that there may be some necessary exceptions to product type level accreditation for methodological reasons. We maintain that recognized accrediting entities provide separate accreditation determinations for each Exchange product/plan since QHP issuers must be accredited on the basis of local performance per § 156.275(a). However, we agree that in some instances, it may be appropriate to combine data for purposes of accreditation, if the combination is reasonable. In the final rule, we are modifying the requirement that recognized accrediting entities provide accreditation at the Exchange product type level to provide accreditation at the Exchange product/plan level, unless combining is methodologically sound. In such cases, the recognized accrediting entity must demonstrate that the Exchange product/plan level accreditation is not practicable. We believe that there are some circumstances in which combining such as combining Exchange product/plan combinations under contiguous states (for example, Exchange HMO in New York and Exchange HMO in New Jersey) or Exchange PPO and Exchange HMO in the same state, or the Department of Insurance and other state regulators in combining data, for pooling the exception.

Comment: One commenter requested clarification on whether NCQA and URAC will be responsible for accrediting dental plans. The commenter suggested that accreditation requirements for dental plans should be developed and be adopted by the Dental Quality Alliance (DQA) to accredit dental plans.

Response: We are not currently requiring that recognized accrediting entities accredit stand-alone dental plans. The Exchange final rule specifies that it is the extent that accreditation standards specify to should about dental plans do not apply. We will consider the DQA's request to assess the accreditation standards and requirements, and dental plans.

Comment: A few commenters recommended allowing plans to meet Exchange quality requirements as part of their annual accreditation process, or requiring a separate accreditation process solely for Exchanges. One commenter recommended that a minimum, lower-level accreditation or a phase-out process provision should apply, since provided legacy-affected entities Exchanges.

Response: We agree with commenters, based on our interpretation of data that will find the recognized accrediting entity uses review policies and procedures that are at least as stringent as those used by the Exchange to review plans as issuers of health plans and products. We intend to establish through future rulemaking standards to ensure that the recognized accrediting entity meet process and standards for accreditation of QHP issuers. We will consider the commenter's recommendations regarding the phase-two recognition process as we develop future rulemaking.

Comment: One commenter requested clarification that the recognized accreditation process would be a process that would be a phased-in accreditation process proposed to phase-out rather than be grandfathered into phase-in recognition.

Response: As we stated in the proposed rule, we maintain that the recognition of accrediting entities in phase one is effective until it is rescinded or this section is modified or revoked. We will consider the role of the PRI process in the phase-out recognized accrediting entities. We intend to establish standards for the phase-out recognition process that we intend to identify in future rulemaking. We will consider the commenter's suggestion that the accreditation process is defined. Only a URAC based entity is recognized for the purposes of QHP certification and this accreditation required, regardless of the process. We will consider the role of the PRI process in the phase-out recognition process.

Comment: A few commenters requested HHS to clearly distinguish the broader quality requirements on Exchanges and health insurance issuers and stated that accreditation should not be considered a permanent substitute for such requirements.

Response: We acknowledge that accreditation is not a substitute for the broader quality requirements included in the Affordable Care Act. We intend to use rulemaking and solicitous future public comment and stakeholder input.

Comment: One commenter recommended that HHS monitor how the accrediting entities change and to periodically place a limit on that they may not be included in the marketed one-time (ABA) calculation. The commenter recommended that the criteria for review in the phase-two recognition process for accrediting entities include full transparency in pricing.

Response: Accreditation must have part of the quality improvement strategy for QHP issuers. We will consider the role of the PRI process when will apply to meet the standards that we will be looking for the phase-two recognition process for accrediting entities, increasing competition.

3. CLINICAL QUALITY MEASURE STANDARDS (§156.275(b)(2))

We proposed that the first condition of recognition is based on section 1311(c)(1) of the Affordable Care Act and 1311(h)(1)(B) and 1301(a)(1)(B) and 1311(c)(1) performance in data categories, which are codified at § 156.275(b)(2) and (3):

- Clinical quality measures such as the Healthcare Effectiveness Data and Information Set (HEDIS);
- Patient experience ratings as a standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS);
- Consumer access;
- Utilization management;
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- Patient information propriety.

We proposed in § 156.275(b)(3)(i) that the clinical quality measures such actions would be the Healthcare Effectiveness Data and Information Set (HEDIS) and/or qualified QHP of the Affordable Care Act and § 1311(h) and (1)(B)(iii). These criteria were chosen based on stakeholder input and to ensure that the Exchange and health insurance issuer's accreditation are aligned with the Exchange enrollee population.

We proposed that the clinical quality measures set must:

- Have a benefit of conditions and diseases, including, but not limited to, chronic illness, that are most prevalent in the Exchange population and have a high impact;
- Include measures that are applicable to adults and pediatric measures that are applicable to children;
- Include the Agency for Healthcare Research and Quality Improvement in Healthcare measures for the Elements and established by Congress, as listed in 2011 data;
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- Only include measures that are different than those required by the Centers for Medicare and Medicaid Services Quality Measures for Medicare Advantage and Prescription Drug Plans and Medicaid Managed Care Plans, if the measures are not in conflict with the Medicare Advantage and Prescription Drug Plans and Medicaid Managed Care Plans and are appropriate and national measures are unavailable or are not available for health plans quality measurement and meet health plans' industry standards; and
- Be evidence-based.

We solicited comments on these standards for clinical quality measures, including whether additional standards for such measures should be included, the standards for rating individual and non-endorsed measures, and whether HHS should require accreditation entities to require health plans to report a specific clinical measures as part of accreditation and if so, which ones.

Comment: One commenter recommended additional criteria for clinical quality measures to include domains such as outcomes and process quality of care and patient satisfaction, be risk adjusted when appropriate, be scientifically sound, be feasible to implement, be meaningful to consumers and purchasers. One commenters recommended prioritizing measures that are being used consistently by public and private sector purchasers and payers. Commenters recommended that the Exchange should include measures that address the prevention including medication prescribing practices, immunization rates, screening services and health plans efforts to reduce health care disparities and to provide culturally competent services.

Response: Much of the recommended criteria for clinical quality measures are consistent with the standards we proposed. We will consider the criteria for accrediting entities being recognized in the interim phase one. We find that, we are maintaining the standards that we proposed for clinical quality measure set. We will consider the recommended criteria for future rulemaking in phase two.

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Response: We agree that NQF plays a significant role in endorsing quality measures. However, we do not require clinical quality measures to reflect or be endorsed by NQF. We will consider the role of the recognized accrediting entities may use alternate measurement set. We maintain the criteria we proposed for the clinical quality measure set. We will consider the commenter's suggestion that the Secretary's measurement standards as part of the future rulemaking in phase two.

Comment: One commenter suggested that the clinical quality measures requirements be recognized accrediting entities include measures that address patients' and families' perspectives and measures that advance primary care services and medical homes.

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Response: We maintain in the final rule that recognized accrediting entities provide separate accreditation determinations for each Exchange product/plan since QHP issuers must be accredited on the basis of local performance per § 156.275(a). We believe that accreditation at the product level is important because it is the most appropriate level for QHP issuers to be accredited on the basis of local performance. We believe that accreditation at the plan or issuer level would also be unreasonable because of the significant variation across the entities performance data reporting.

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Response: We understand that there may be some necessary exceptions to product type level accreditation for methodological reasons. We maintain that recognized accrediting entities provide separate accreditation determinations for each Exchange product/plan since QHP issuers must be accredited on the basis of local performance per § 156.275(a). However, we agree that in some instances, it may be appropriate to combine data for purposes of accreditation, if the combination is reasonable. In the final rule, we are modifying the requirement that recognized accrediting entities provide accreditation at the Exchange product type level to provide accreditation at the Exchange product/plan level, unless combining is methodologically sound. In such cases, the recognized accrediting entity must demonstrate that the Exchange product/plan level accreditation is not practicable. We believe that there are some circumstances in which combining such as combining Exchange product/plan combinations under contiguous states (for example, Exchange HMO in New York and Exchange HMO in New Jersey) or Exchange PPO and Exchange HMO in the same state, or the Department of Insurance and other state regulators in combining data, for pooling the exception.

Comment: One commenter requested clarification on whether NCQA and URAC will be responsible for accrediting dental plans. The commenter suggested that accreditation requirements for dental plans should be developed and be adopted by the Dental Quality Alliance (DQA) to accredit dental plans.

Response: We are not currently requiring that recognized accrediting entities accredit stand-alone dental plans. The Exchange final rule specifies that it is the extent that accreditation standards specify to should about dental plans do not apply. We will consider the DQA's request to assess the accreditation standards and requirements, and dental plans.

Comment: A few commenters recommended allowing plans to meet Exchange quality requirements as part of their annual accreditation process, or requiring a separate accreditation process solely for Exchanges. One commenter recommended that a minimum, lower-level accreditation or a phase-out process provision should apply, since provided legacy-affected entities Exchanges.

Response: We agree with commenters, based on our interpretation of data that will find the recognized accrediting entity uses review policies and procedures that are at least as stringent as those used by the Exchange to review plans as issuers of health plans and products. We intend to establish through future rulemaking standards to ensure that the recognized accrediting entity meet process and standards for accreditation of QHP issuers. We will consider the commenter's recommendations regarding the phase-two recognition process as we develop future rulemaking.

Comment: One commenter requested clarification that the recognized accreditation process would be a process that would be a phased-in accreditation process proposed to phase-out rather than be grandfathered into phase-in recognition.

Response: As we stated in the proposed rule, we maintain that the recognition of accrediting entities in phase one is effective until it is rescinded or this section is modified or revoked. We will consider the role of the PRI process in the phase-out recognized accrediting entities. We intend to establish standards for the phase-out recognition process that we intend to identify in future rulemaking. We will consider the commenter's suggestion that the accreditation process is defined. Only a URAC based entity is recognized for the purposes of QHP certification and this accreditation required, regardless of the process. We will consider the role of the PRI process in the phase-out recognition process.

Comment: A few commenters requested HHS to clearly distinguish the broader quality requirements on Exchanges and health insurance issuers and stated that accreditation should not be considered a permanent substitute for such requirements.

Response: We acknowledge that accreditation is not a substitute for the broader quality requirements included in the Affordable Care Act. We intend to use rulemaking and solicitous future public comment and stakeholder input.

Comment: One commenter recommended that HHS monitor how the accrediting entities change and to periodically place a limit on that they may not be included in the marketed one-time (ABA) calculation. The commenter recommended that the criteria for review in the phase-two recognition process for accrediting entities include full transparency in pricing.

Response: Accreditation must have part of the quality improvement strategy for QHP issuers. We will consider the role of the PRI process when will apply to meet the standards that we will be looking for the phase-two recognition process for accrediting entities, increasing competition.

3. CLINICAL QUALITY MEASURE STANDARDS (§156.275(b)(2))

We proposed that the first condition of recognition is based on section 1311(c)(1) of the Affordable Care Act and 1311(h)(1)(B) and 1301(a)(1)(B) and 1311(c)(1) performance in data categories, which are codified at § 156.275(b)(2) and (3):

- Clinical quality measures such as the Healthcare Effectiveness Data and Information Set (HEDIS);
- Patient experience ratings as a standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS);
- Consumer access;
- Utilization management;
- Quality improvement;
- Provider credentialing;
- Complaints and appeals;
- Network adequacy and access; and
- Patient information propriety.

We proposed in § 156.275(b)(3)(i) that the clinical quality measures such actions would be the Healthcare Effectiveness Data and Information Set (HEDIS) and/or qualified QHP of the Affordable Care Act and § 1311(h) and (1)(B)(iii). These criteria were chosen based on stakeholder input and to ensure that the Exchange and health insurance issuer's accreditation are aligned with the Exchange enrollee population.

We proposed that the clinical quality measures set must:

- Have a benefit of conditions and diseases, including, but not limited to, chronic illness, that are most prevalent in the Exchange population and have a high impact;
- Include measures that are applicable to adults and pediatric measures that are applicable to children;
- Include the Agency for Healthcare Research and Quality Improvement in Healthcare measures for the Elements and established by Congress, as listed in 2011 data;
- Include the Centers for Medicare and Medicaid Services Quality Measures for HHS and the Health and Human Services Secretary's Priority Measures (http://www.healthcare.gov/news/factsheets/exchange/national-quality-measures.html);
- Only include measures that are different than those required by the Centers for Medicare and Medicaid Services Quality Measures for Medicare Advantage and Prescription Drug Plans and Medicaid Managed Care Plans, if the measures are not in conflict with the Medicare Advantage and Prescription Drug Plans and Medicaid Managed Care Plans and are appropriate and national measures are unavailable or are not available for health plans quality measurement and meet health plans' industry standards; and
- Be evidence-based.

We solicited comments on these standards for clinical quality measures, including whether additional standards for such measures should be included, the standards for rating individual and non-endorsed measures, and whether HHS should require accreditation entities to require health plans to report a specific clinical measures as part of accreditation and if so, which ones.

Comment: One commenter recommended additional criteria for clinical quality measures to include domains such as outcomes and process quality of care and patient satisfaction, be risk adjusted when appropriate, be scientifically sound, be feasible to implement, be meaningful to consumers and purchasers. One commenters recommended prioritizing measures that are being used consistently by public and private sector purchasers and payers. Commenters recommended that the Exchange should include measures that address the prevention including medication prescribing practices, immunization rates, screening services and health plans efforts to reduce health care disparities and to provide culturally competent services.

Response: Much of the recommended criteria for clinical quality measures are consistent with the standards we proposed. We will consider the criteria for accrediting entities being recognized in the interim phase one. We find that, we are maintaining the standards that we proposed for clinical quality measure set. We will consider the recommended criteria for future rulemaking in phase two.

Comment: Several commenters expressed concern that clinical quality measure standard used by current accrediting entities and the CAHPS survey process do not include people with disabilities. Several commenters recommended that HHS should require that the accreditation process should address healthcare and rehabilitation critical quality measures, the evaluation of quality of life beyond that represented by the typical quality healthcare and network adequacy.

Response: As part of future rulemaking in the phase two recognition process, we will consider these standards.

Comment: One commenter requested clarification regarding which CAHPS survey would be used for the purposes of accreditation, and whether the CAHPS survey will be developed. The commenter expressed the view of preference that the CAHPS Hospital Care Survey and the Christian Group CAHPS as proposed measures tools and recommended if plans or providers such as advanced practice registered nurses and certified registered nurse anesthetists in the Exchange are recommended to be adequately capture the patient and caregiver experiences.

Response: We are finalizing the requirement that the recognized accrediting entities require accreditation to find participation in a patient experience survey as a standardized CAHPS survey. We are not specifying which CAHPS survey is to be used. We intend to establish through future rulemaking standards to ensure that the recognized accrediting entities will use the appropriate CAHPS survey and will use the original core and/or Clinician/Group CAHPS surveys.

Comment: Several commenters expressed support that accreditation include, in the phase two recognition process, the Agency for Healthcare Research and Quality's recognized consumer materials setting forth a. A few commenters stated that measures should be based on national standards such as National Quality Forum (NQF) and National Committee for Quality Assurance (NCQA) and that the language related to measures that are developed or adopted by a consumer consensus standards setting body. This commenter recommended that CMS/ HHS should require that the Exchange quality measures and reporting standards are authorized by the entity with a contract with the Secretary, which is currently with the National Quality Forum (NQF).

Response: We agree that NQF plays a significant role in endorsing quality measures. However, we do not require clinical quality measures to reflect or be endorsed by NQF. We will consider the role of the recognized accrediting entities may use alternate measurement set. We maintain the criteria we proposed for the clinical quality measure set. We will consider the commenter's suggestion that the Secretary's measurement standards as part of the future rulemaking in phase two.

Comment: One commenter suggested that the clinical quality measures requirements be recognized accrediting entities include measures that address patients' and families' perspectives and measures that advance primary care services and medical homes.

Response: We believe that the patient perspective is captured by the requirement that accreditation entities include measures that address patient experience of care survey as (§156.275 (a)(2)). We also maintain in the final rule that clinical quality measures be aligned with priorities of the National Strategy for Quality Improvement in Healthcare (NSQIHC). The NSQIHC's priorities include patient-centered care, process improvement, population health improvement and strengthening primary care using models such as patient-centered medical homes.

Comment: A few commenters recommended requiring independent auditing of results as an additional clinical quality measures considered as part of recertification to ensure the accuracy and comparability of results, to provide a level of confidence being by plans, and to build support among stakeholders.

Response: While independent auditing of results could be an effective way to ensure accuracy and to provide a level of confidence and stakeholders to measures

the Exchange that supplies QHP products in that area.

Such disclosure must include at least the following measures: during the annual certification period or a change-in-status event in those data throughout the year, the Exchange must provide to the issuer of a QHP offered in a service category of information should be included.

The proposed rule would permit Exchanges to arrange additional data sharing agreements with the recognized accrediting entities if they choose, such as information on the QHP issuer's policies and procedures. We solicited comments on the potential benefits and burdens associated with the additional information upon request from Exchanges.

Comment: Several commenters recommended that recognized accrediting entities provide the Exchange a copy of the most recent accreditation survey for each accredited product as well as any corrective action plans and summaries of deficiencies. Some commenters suggested that Exchanges should have the issuer's file, the accrediting entity's file, or a summary of pertinent records regarding the volume of proprietary health plan data and data containing personally identifiable information. Some commenters suggested that the data sharing should be limited to quality measures and CAHPS survey results that will be displayed and not include the full accreditation survey or additional information that is not relevant to consumers. Some commenters also suggested requested that data be shared with state quality improvement organizations for additional oversight.

Response: 45 CFR 156.275(b)(2) requires QHP issuers to authorize the accrediting entity to release to the Exchange survey related information such as corrective action plans and summaries of deficiencies. We anticipate that QHP issuers that the recognized accrediting entity provides through data sharing agreements to an Exchange. We interpret this regulation to permit an Exchange to request the full survey and other information from the accrediting entity. We believe that the data sharing requirements between the recognized accrediting entities and Exchanges to expressly include personally identifiable data.

Comment: One commenter requested more information regarding the process for recognized accrediting entities to provide data to Exchanges.

Response: We will be working closely with the recognized accrediting entities to further clarify the process including definitions of data elements.

Comment: One commenter requested clarification on whether accreditation data should be provided to Exchanges for all products or just those that are offered and whether a recognized accrediting entity can collect authorization from issuers to release data elements to an Exchange.

Response: Because it will take time for QHP product type-specific accreditation to be available, consistent with the proposed rule, recognized accrediting entities may provide accreditation data for all products. We anticipate that Exchanges will use Exchange products for example, commercial and Medicaid if they deem it are requested by an Exchange, once the QHP issuer authorizes the release of data. We believe that a recognized accrediting entity can collect from the QHP issuer accreditation survey data on all products in its accreditation survey.

Comment: One commenter requested clarification regarding what clinical quality and CAHPS measure results data must be reported (for example, numerators and denominators only or more detailed data like member level survey results).

Response: The clinical quality measure results and adult and child CAHPS measure survey results specified in the final rule are the only data measure results that are required to be provided by the recognized accrediting entity to the Exchange. Accreditation data that is specific the level of detail that is appropriate and reasonable for the QHPs, as we set further defining the level of reporting of these data for the Exchange.

Comment: One commenter requested clarification regarding what is meant by "information on enrollees" in the proposed rule at 45 CFR 156.275(b)(3). The commenter stated that there should be additional clarification for what data collection by Issuers, but not necessarily at the issuer (Bronze, Silver, Gold or Platinum level.

Response: We recognize that adequate sample size for valid data collection is a concern and we will be working closely with the Exchanges and Issuers to facilitate a response related and CAHPS data at the QHP product or plan level if there are adequate sample sizes to capture the QHP experience and enable reporting of valid and reliable performance measures.

Comment: One commenter recommended that CMS collect accrediting entity information and data on behalf of the Exchanges to avoid duplicative requirements to support QHP network adequacy or network adequacy information demonstration requirements.

Response: We agree that these data could support the Exchange in the review of network adequacy standards as part of QHP certification. however, at this time, we do not plan to collect network adequacy information from accrediting entities. We survey data elements relating to network adequacy requirements, that are in excess of the disclosure required under § 156.275(b)(2), in the Exchange.

III. Provisions of the Proposed Regulations

This final rule incorporates the provisions of the proposed rule with some minimum modifications, along with additional provisions to Exchanges to improve clarity, and noted here. These provisions of the final rule that differ from the proposed rule are as follows:

Section § 156.715(a)

Section 156.715(a) of the Federal Regulations Includes only quantitative limits, which also removes the requirement to provide data on nonquantitative limits for purposes of this final rule.

Section § 156.275(a)

Establishes a substantive deadline for applicable issuers. Issuer submission of data to Exchanges.

Section § 156.275(a)(2)(i)

- Establishes exceptions authority to the product type level accreditation requirement, consistent with the proposed rule, and provides that the recommendation should include the accreditation entity, including issuer, must demonstrate that the Exchange product type level accreditation is not available or practicable, and that the Exchange product type level exception is authorize accreditation or an aggregated QHP.

Section § 156.275(a)(2)(ii)

- Requires submission of accreditation summary provision under the network adequacy and quality improvement.
- Maintains that network adequate standards for accreditation by, or equivalent to, the standards of the National Committee for Quality Assurance for QHP issuers certified in all specialized and PCP.

Section § 156.275(a)(3)(i)

- Establishes a substantive deadline for data of publication of the final rule that an accrediting entity must provide current accreditation standards and information to Exchanges, including the Exchange's Navigator and Navigator resources to demonstrate that such entity meets the certification specifications.

Section § 156.275(a)(3)(ii)

- Clarifies that recognized accrediting entities must provide to HHS any information that HHS requests to monitor and evaluate the Exchange's measure specification for performance measures with its data prior to public authorization.

Section § 156.275(a)(5)

- Adds an exception to process personally identifiable information.

IV. Collection of Information Requirements

As part of the proposed rule, and in accordance with the Paperwork Reduction Act, we sought comment on the information collection requests (ICRs) contained in the proposed rule. We received no comments on the ICRs in the proposed rule. Collection. We received some comments on this section, which are discussed below. As described above, we finalize § 156.1010 as it was proposed, with the exception of the data elements in § 156.275(a)(2)(ii) and § 156.715(a)(1) and (2), as noted in the **Federal Register** notice (77 FR 1444) and including comments on the revisions to the information collection request (ICRs). "Health Care Reform Insurance Web Portal Requirements" (CMS-9957-P).

In the proposed rule and the Notice, it states that the **Federal Register** Notice, we estimated that the burden associated with the information collection requests contained in this Rulemaking, including the data collection of a benchmark and the voluntary data collection from stakeholders listed plans. We received some comments on the burden of the ICRs in the proposed rule. We discussed the ICRs in the Office of Management and Budget for review and approval. We finalize the ICRs as benchmark data collection and voluntary data collection from stakeholders listed plans. "Health Care Reform Insurance Web Portal Requirements". The estimated period for this package changes upon through August 2, 2012, and we encourage interested parties to submit comments.

In the proposed rule, we also sought comment on ICRs contained in recording entities (§ 156.275). We did not receive comments on the accrediting entities (§ 156.275). We finalize the ICRs as it was proposed, with the exception of the data elements in § 156.275(a)(2)(ii) and § 156.715(a)(1) and (2), as noted in the **Federal Register** notice accrediting comments on the revisions to the information collection request (ICRs). "Health Care Reform Insurance Web Portal Requirements" (CMS-9957-P).

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We estimate that it will take four hours for a health insurance issuer to meet this reporting requirement, including data collection, submission, and analysis. This estimate is based on internal industry sources collected to monitor the implementation of the Medicaid Health Care Management Information Reporting Program. Given that the three health insurance issuers with the largest products by enrollment in each state (including the District of Columbia) would be required to submit information for each product, we estimate that the burden of complying with the reporting requirement would require four hours for one employee at a cost of $70 an hour, based on the hourly cost reported by Bureau of Labor Statistics for a medical and health services manager (Medical Long Program which requires employers to provide medical coverage for a total cost of $280 a year per issuer. The total number of respondents required to report is 9 (3 issuers in each of the three largest markets in each state and District of Columbia) for a total burden of 36 hours. Assuming 52 work-weeks per year, multiplied by 9 respondents, the total burden is 468 hours (36 hours x 9 = 468 hours).

Comment: We received some comments reporting concern that HHS's burden estimate is underestimated in the proposed data collection rule.

Response: We appreciate these concerns, but for the reasons discussed above, believe that our estimates accurately reflect the burden of reporting.

Comment: One commenter recommended that HHS avoid collection of an "other" benefit category because the category is essentially undefined.

Response: HHS included the "other" category to allow for full reporting of the information required by the statute. We will be working closely with the Exchanges and issuers to clarify reporting.

V. Regulatory Impact Analysis

Data was conducted the impact of the final rule as required by Executive Orders 12866 on Regulatory Planning and Review (September 30, 1993) and Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011). Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, reducing uncertainty, and considering incentives.

It is HHS's belief that this rule does not reach this economic threshold and thus is not considered a major rule. This rule consists of a data collection from a limited number of health insurance issuers and a data submission by two recognized accrediting entities. The data collection from health insurance issuers, we do not anticipate that there would be any economic impact with this rulemaking in addition to those costs, as outlined below. We derived the costs associated with the data collection from the Medicaid Health Care Management Information Reporting Program. The data collection from issuers will applies to the issuers of the three largest products by enrollment in each state's small group market, which will be a subset of the issuers that will be required to report data for the medical loss ratio and access of issuers of 45 CFR 158. Additionally, HHS has recognized the proposed rule requested that issuers that sold in other small group markets in the state, in addition to those that are the three largest products by enrollment, should be included in the number of significant covered issuers in a substantial number of small entities a change in revenues of more than 3 percent.

The HHS response agrees to market options for regulatory relief of small businesses, if a proposed rule has a significant impact on a substantial number of small entities. HHS, in the Office of Management and Budget, consulted with recognized organizations, and small government jurisdictions. Small businesses are those with data below thresholds established by the Small Business Administration (SBA).

As discussed above, this final rule is necessary to implement certain standards for the Exchanges and recognized accrediting entities, and to implement accrediting activities as authorized by the Affordable Care Act. Specifically, this rule outlines collecting data from issuers that offer the three largest small group market products in each state, and data from two of the three largest recognized accrediting entities. For the purposes of the regulatory flexibility analysis, we expect the following types of entities to be affected by this final rule: (1) QHP issuers and (2) HHS, and (3) Exchanges.

As discussed in the Medicaid Health Care Reform Act (45 CFR Special), Act, if a rule would have a significant impact on a substantial number of small entities, established by the SBA. In the rule, we used a data set created from data National Association of Insurance Commissioners (NAIC) Health and Life Blank Data Set and Medicaid Health Care Management Information Reporting Program and Audited data with comprehensive major medical coverage in the individual and group markets. For purposes of this analysis, the Department used total revenue and health control premiums to calculate annual receipts. We estimated that there are 28 small entities with less than $7 million in annual receipts. Based on the information, we believe that the proposed rule would not have a significant economic impact. However, this estimate may overstate the actual number of small health insurance issuers offering such coverage, since it does not include information on ownership. Based on the information, we believe that the proposed rule that issuers that would be considered small businesses are likely to be subsidiaries of larger insurers that are not small businesses.

The rule also directs two accrediting entities, NCQA and URAC, to submit documentation to HHS. The SEA, as stated previously, considers a non-profit organization to be a small business if it has annual receipts of $7 million. Both NCQA and URAC business they are the two non-profit dominant actors in the field of health plan accreditation. NCQA is a not for-profit entity that has been in operation since 1979 and has accredited health plans since 1991 and accrediting hospitals and ambulatory care and quality measures. NCQA has accredited health plans covering over 70 percent of all Americans.[1] URAC is also a not-for-profit organization that has been in operation since 1990 and has accredited health plans since 1991.[2] Finally, based on their dominant role in accrediting health plans, we believe that NCQA and URAC are not small businesses. Other entities accrediting the Small Business administration are marketed.[3]

Based on the foregoing, we are not proposing an analysis for the SEA because we have determined, and the Secretary certifies, that the final rule would not have a significant economic impact on a substantial number of small entities.

VI. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits prior to proposed rule before issuing a final rule that includes any Federal mandate that may result in expenditure in any one year by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million. This rule does not affect spends for inflation. In 2012, that threshold is approximately $130 million. This rule does not mandate any State, local, or tribal government, in the aggregate, or by the private sector, of $100 million. The Department of Health and Human Services, that threshold is approximately $130 million. This rule does not mandate any State, local, or Tribal governments, or to the private sector, of $100 million in any one year. Accordingly, we have not prepared a statement of the costs and benefits of this rule.

VII. Federalism

Executive Order 13132 establishes certain requirements that an agency must adhere to when promulgating a policy that has Federalism implications, that preempts State law, or that imposes a substantial direct cost of compliance on State and local governments, preempts State law, or imposes a direct compliance cost on State and local governments, preempts State law, or otherwise has Federalism implications. This final regulation, as it relates to the recognition of accrediting entities, does not impose any costs on State and local governments. The rule regulation includes reporting requirements of State and local governments.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have Federalism implications or that preempt State authority, we certify that this regulation is not in conflict with or does not impose any costs on State and local governments, preempt State law, or otherwise have Federalism implications. We note that states that choose to select a benchmark plan will be required to provide information to the Exchange and HHS. We will provide information to the Secretary about the plan name (based on a benchmark plan) and the plan's covered benefits. We believe that the information we are asking for is a minimal burden on the states, and that the information is not burdensome.

Pursuant to the requirements set forth in section 804(2) of Executive Order 13132 and by the signature affixed to this regulation, the Department of Health and Human Services certifies that CMS has complied with the requirements of Executive Order 13132 for the attached regulation in a meaningful and timely fashion.

List of Subjects in 45 CFR Part 156

- Advertising and promotional practices and procedures
- Advertising
- Advisory Committees
- Brokers
- Consumer protection
- Consumer protection
- Grant programs—health
- Grants administration
- Health care
- Health care costs
- Health care
- Health maintenance organization (HMO)
- Health records
- Hospitals
- Insurance
- Individuals with disabilities
- Loan programs—health
- Organization and functions (Government agencies)
- Penalties
- Public assistance programs
- Reporting and recordkeeping requirements
- Taxes
- State and local governments
- Technical assistance
- Technical assistance
- Women
- and Youth

For the reasons set forth in the preamble, the Department of Health and Human Services amends 45 CFR subchapter B, chapter 1, as set forth below.

PART 156—HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

1. The authority citation for part 156 is revised to read as follows:

Authority: Title I of the Affordable Care Act, Sections 1311 (a)(4), 1321 (a), 1411 (a)(2), 1412 (a)(1), 1413 (a) and (b), 1414 (a), 1415, 1421, 1422, 1431, 1436, 1441, 1442, 1443, 1444, 1445.

2. Add subpart D to part 156 to read as follows:

Subpart D—Standards for Essential Health Benefits, Actuarial Value, and Cost Sharing

§ 156.100 Collection of data from certain issuers to define essential health benefits.

(a) Definitions. The following definitions apply to this section, unless the context indicates otherwise:

Health insurance benefits. Health benefits as defined in paragraph (b) of this section.

Health plans. Health plan the meaning given in the term § 156.20 of this chapter.

Health plan that the meaning given in the term, "Portal Plan" in § 156.20 of this chapter.

Small group market the meaning given in the term in § 155.20 of this chapter.

State law the meaning given in the term in § 155.20 of this chapter.

Treatment limitations include limits on benefits based on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative and nonquantitative limits. Limits in permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation.

(b) *Required information.* The issuers described in paragraph (c) of this section must provide the following information to the health plans described in paragraph (d) of this section in accordance with the standards in paragraph (e) of this section:

(1) Administrative data necessary to identify the health plan;

(2) Data and description information for each plan as the following items:

(i) A full health benefits to the plan;

(ii) Treatment limitations;

(iii) Prescriptions; and

(iv) Rates.

(c) Issuers required to report. The issuers that offer the three largest products by enrollment in each state (including the District of Columbia) determined by HHS based on data calculated in accordance with part (iii) of this (c) stock state's small group market must provide the information in paragraph (b) of this section.

(iii) Plans affected. The issuers described in paragraph (c) of this section must provide the information in paragraph (b) of this section for the health plan with the highest enrollment in determined in accordance with the criteria in paragraph (c) of this section.

(iv) Reporting requirement. To ensure consistency in reporting, an issuer described in paragraph (c) of this section must, in lieu, in any and manner to be determined by HHS, the information described in paragraph (b) of this section to HHS not later than September 1, 2012.

(v) Issuers's (a) (c) by selling paragraph (c) to read as follows:

§ 156.275 Accreditation of QHP Issuers.

(a) Accreditation.

(1) Accreditation—(i) Description of accrediting entity by HHS. Effective upon completion of implementation of Sections 1311 (a) (4) (A) (ii), and (c)(1) of the section, or which date HHS will notify the public of the date, the Secretary of Health and Human Services (Secretary) (HHS and CMS) are recognized of accrediting entities the Secretary of HHS provides accreditation of QHPs meeting the requirement of this section.

(ii)(1) Scope of accreditation. Subject to paragraphs (a)(2)(i), (ii), and (iii) of this section, HHS may recognize an accrediting entity's accreditation within the categories identified in paragraph (a)(2) of this section.

(2) Plans qualify measures. Recognized accrediting entities must include a clinical quality measure set in their accreditation standards for health plans that

(i) Spans a breadth of conditions and measures, including, but not limited to, those that address prevention and enhance chronic disorders, chronic care, and acute care;

(ii) Includes measures that are applicable to adults and measures that are applicable to children;

(iii) 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 21, 2011;

(iv) Will, further measures that are either developed or adopted by a voluntary consensus standards setting body (such as those described in section 1890 of the Social Security Act, including those endorsed by the NQF) and utilize a Department of Management and Budget (OMB) Circular A-119 (1998) or, where applicable and relevant measures are unavailable, use in a manner not for health plan quality measurement and non-health plan industry standards; and

(v) Is evidence-based.

(iii) Level of accreditation. Recognized accrediting entities must provide accreditation at the Exchange product type level, except in circumstances where the Secretary determines that a product type level accreditation is not available or practicable, and that a product type level exception is authorize accreditation or an aggregated QHP.

(iv)(1) Annual adequacy. The network adequate standards for accreditation by, or equivalent to, the standards of the National Committee for Quality Assurance, for consumers certified by recognized organizations by contracts adequate for QHP issuers certified in all specialized and PCP.

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

(3) Discontinuation. An accrediting entity must provide the following discontinuation:

(i) To be recognized, an accrediting entity must provide current accreditation standards and information to Exchanges, including the Exchange's Navigator and Navigator resources to demonstrate that such entity meets the certification described in paragraphs (1)(2) and (3)(i) of this section, and (ii) to HHS, the information described in paragraph (3)(ii) of this section, and (iii) to HHS, the information described in paragraph (3)(iii) of this section.

(ii) Information to HHS. Information to HHS to be provided, in the manner, the current indicator otherwise:

(iii) Information to Exchanges. Information to Exchanges, including the Exchange's Navigator and Navigator resources to demonstrate that such entity meets the certification described in paragraphs (1)(2) and (3)(i) of this section, and (ii) to HHS, the information described in paragraph (3)(ii) of this section, and (iii) to HHS, the information described in paragraph (3)(iii) of this section.

(b) Information collection.

(1) Level of accreditation. Recognized accrediting entities must provide accreditation at the Exchange product type level, except in circumstances where the Secretary determines that a product type level accreditation is not available or practicable, and that a product type level exception is authorize accreditation or an aggregated QHP.

(2) Network adequacy. The network adequate standards for accreditation by, or equivalent to, the standards of the National Committee for Quality Assurance, for consumers certified by recognized organizations by contracts adequate for QHP issuers certified in all specialized and PCP.

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

(c) Discontinuation. An accrediting entity must provide the following discontinuation:

(1) To be recognized, an accrediting entity must provide current accreditation standards and information to Exchanges, including the Exchange's Navigator and Navigator resources to demonstrate that such entity meets the certification described in paragraphs (1)(2) and (3)(i) of this section, and (ii) to HHS, the information described in paragraph (3)(ii) of this section, and (iii) to HHS, the information described in paragraph (3)(iii) of this section.

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(f) Information collection.

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(h) Information collection.

(1) Level of accreditation. Recognized accrediting entities must provide accreditation at the Exchange product type level, except in circumstances where the Secretary determines that a product type level accreditation is not available or practicable, and that a product type level exception is authorize accreditation or an aggregated QHP.

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(j) Information collection.

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(l) Information collection.

(1) Level of accreditation. Recognized accrediting entities must provide accreditation at the Exchange product type level, except in circumstances where the Secretary determines that a product type level accreditation is not available or practicable, and that a product type level exception is authorize accreditation or an aggregated QHP.

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(n) Information collection.

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(p) Information collection.

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(r) Information collection.

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(v) Information collection.

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

(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, other than personally identifiable information (as described in OMB Memorandum M-07-16), 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.

Dated: July 16, 2012.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: July 16, 2012.

Kathleen Sebelius,

Secretary.

Footnotes

1. *Available at: http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.*
Back to Citation

2. *Available at: http://cciio.cms.gov/resources/files/largest-smgroup-products-7-2-2012.pdf.PDF.*
Back to Citation

3. *Available at: http://cciio.cms.gov/resources/files/largest-smgroup-products-7-2-2012.pdf.PDF.*
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4. *Exchange Final Rule published in 77 FR 18310 at 18412 (March 27, 2012).*
Back to Citation

5. *We expect the QHP issuer will provide the accrediting entity with the HIOS identifiers.*
Back to Citation

6. *Available at: http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS1247405.html.*
Back to Citation

7. *Available at: http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/cms-10435.html.*
Back to Citation

8. *According to the Small Business Administration size standards, entities with average annual receipts of $7 million or less would be considered small entities for North American Industry Classification System (NAICS) Code 524114 (Direct Health and Medical Insurance Carriers) (for more information, see "Table of Size Standards Matched To North American Industry Classification System Codes," effective March 26, 2012, U.S. Small Business Administration, available at http://www.sba.gov).*
Back to Citation

9. *See "About NCQA," NCQA Web site. Available at http://www.ncqa.org/tabid/675Default.aspx.*
Back to Citation

10. *See "Frequently Asked Questions" URAC Web site. Available at: https://www.urac.org/about/faqs.aspx#General.*
Back to Citation

11. *According to the Small Business Administration size standards, entities with average annual receipts of $7 million or less would be considered small entities for North American Industry Classification System (NAICS) Code 524298 (All Other Insurance Related Activities) (for more information, see "Table of Size Standards Matched To North American Industry Classification System Codes," effective March 26, 2012, U.S. Small Business Administration, available at http://www.sba.gov).*
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