Rhode Island Health Insurance Enforcement & Consumer Protection Cycle I Grant

Project Narrative

A. Eligibility

The State of Rhode Island Office of the Health Insurance Commissioner (OHIC) has broad authority under its purposes statute to (a) guard the solvency of health insurers; (b) protect the interests of consumers; (c) encourage policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and (d) view the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access.[1] With this authority and through its regulations[2], Rhode Island is currently enforcing ACA market reforms and consumer protections under Part A of title XXVII of the PHS Act and is not receiving other Federal grant dollars for the same market reforms activities for which we are pursuing funding under the Health Insurance Enforcement and Consumer Protections grant.

B. Description of Current Market Reform Processes

OHIC has a comprehensive and innovative form and rate review process for the individual, small group, and large group insurance markets. OHIC has been awarded four Rate Review Grants totaling of $8.5 million and to date, has made significant progress on the goals of these grants, as reflected in our quarterly reports submitted to the federal government. In addition to OHIC's work on the rate review side, OHIC has also strengthened its form review function, analyzing hundreds of plan designs each year to ensure that they meet federal and state requirements.

[1] OHIC Purposes Statue: http://webserver.rilin.state.ri.us/Statutes/title42/42-14.5/42-14.5-2.HTM

[2] Statutes that reference access, continuity, and quality of services and OHIC's authority over carriers and the ability to perform market conduct examinations: RIGL Section 27-13.1-4; 23-17.13; 27-41; 27-18; 27-19; and 27-20

We propose to use funds available through the "Grants to States for Planning and Implementing the Insurance Market Reforms Cycle I" to address the following four market reform and consumer protection provisions under Part A of Title XXVII of the PHS Act:

1. Section 2707: Non-discrimination under Comprehensive Health Insurance Coverage
2. Section 2713: Coverage of Preventive Health Services
3. Section 2719: Appeals Process
4. Section 2726: Parity in Mental Health and Substance Use Disorder Benefits

OHIC will fulfill these Cycle I grant objectives through the activities proposed and detailed in this application. We will improve the effectiveness of our policy form review and coverage enforcement, market conduct examinations, and the consumer appeals process. The current status of each of these four market reform activities will be described in further detail below.

Rhode Island's Form Review Process and Regulatory Structure

As of March 2016[3], there were approximately 220,212 covered lives in the fully-insured Rhode Island health insurance market. There are four major issuers in the commercial market, excluding those that cover only individuals over 65 years of age: Blue Cross Blue Shield of Rhode Island (BCBSRI), UnitedHealthcare (United), Tufts Health Plan (Tufts), and Neighborhood Health Plan of Rhode Island (NHPRI). OHIC has jurisdiction over Rhode Island's fully-insured commercial health insurance market, which includes the individual market, small group market, and large group market. BCBSRI, United, NHP, and Tufts comprise 74%, 14%, 8%, and 4% of the fully-

[3] Data from Issuer Rate Filings submitted in May 2016.

insured market share respectively. The individual and small group markets account for 20% and 27% of the fully-insured health insurance market respectively.

Form Review and Regulatory Structure

Under the Rate Review Grants, OHIC has not only strengthened and formalized its rate review and Affordability Standards work, but it has also used these funds to hire staff, build up, and internalize policies and procedures related to form review. This work includes:

- Institutionalizing the form and rate review process by developing a policies and procedures manual that outlines OHIC's regulatory authority to conduct form and rate review, the timeline and documents associated with filings, staff functions, and the review process.
- Hiring staff (some of whom we are proposing to continue to fund through this grant) to conduct a thorough and comprehensive form review process, with a focus on collecting and analyzing complaints and benefit coverage issues from both a provider and consumer perspective. Under the rate review grants, staff has started the process of expanding form review beyond document-level compliance but this grant would further enhance and expand this work.
- Developing a formal process for market conduct exams, including incorporating the usage of data from Rhode Island's All-Payer Claims Database (APCD).

Annual Form Review Process for the Individual and Small Group Market

The timeline for OHIC's annual form review process is as follows:

November-March: Prepare and release form filing instructions. This includes soliciting feedback from interested parties, including the issuers and HealthSource RI (Rhode Island's state-based marketplace) and revising the form filing instructions to reflect compliance with changes in state

or federal statute or regulation as well as coverage issues surfacing since issuance of previous instructions. Current form filing instructions are made available on SERFF.

April: Standard Form filings for Individual and Small Group plans are due. Preliminary review begins. Standard forms include: Certificates of Coverage, Group Policies, and Schedules of Benefit listing Essential Health Benefits (EHB), Rhode Island Benefit Mandates, benefit exclusions and standard benefit provisions set forth in applicable federal and state health insurance regulations. These documents do not include benefit design cost shares.

May: Detailed form filings for Individual and Small Group plans are due – these documents contain specific consumer cost-sharing information and network design, including the detailed Schedules of Benefits for Medical/Surgical, Dental, Vision, and Prescription Drugs.

June-August: Review of form filings for compliance with state and federal requirements and decisions issued.

OHIC staff review each form filing for compliance with the Form Filing Instructions. A selection of review criteria are included below:

a. Checking for annual or lifetime dollar limits for EHBs.

b. Checking to see that preventive services listed in the filed certificates are covered without cost sharing. OHIC is proposing to enhance and improve upon work in this area using this funding opportunity.

c. Checking for a cancellations and terminations policy that is consistent with state and federal requirements.

d. Ensuring that the plan provides coverage for parity in mental health and substance use disorder benefits. OHIC is proposing to enhance and improve upon work in this area using this funding opportunity.

e. Ensuring issuers follow state and federal rules around the provision of habilitative and rehabilitative services.

f. Ensuring coverage for all state benefit mandates and review for compliance with all standard insurance provisions found in state and/or federal statutes.

g. Checking for processes that inform enrollees and providers of prescription drug formulary changes and exceptions.

All aspects of the form review process are coordinated with the rate review process which occurs in the same timeframe. Many decisions or clarifications on the form review side can affect premium development and OHIC staff work closely to ensure that the two processes are aligned and the issuers are receiving clear and consistent guidance. During this process, OHIC also solicits and incorporates the input of key stakeholders, including its Health Insurance Advisory Council, and of the general public. All fully-insured form/rate filings are publicly disclosed and prominently posted on OHIC's website and are available through SERFF.

Current Capacity for Selected Market Reforms

Section 2707 – Non-Discrimination under Comprehensive Health Insurance Coverage

OHIC currently examines compliance with the non-discrimination provisions for EHBs at a high-level. However, OHIC shares the federal government's concern that discriminatory benefit designs could discourage people with potentially high-cost medical conditions from enrolling in coverage

and plans to use grant funds under this opportunity to review plan designs at a more detailed and granular level to ensure that issuers are not including discriminatory benefit designs.

During the course of OHIC's annual form review process for the fully-insured market, we have examined areas of benefit discrimination related to age, health conditions, and high cost pharmaceuticals. However, the addition of federal grant funds to further enhance and support this work would allow us to perform more in-depth analyses and develop standard operating procedures and/or tools in this area, including a focus on selected chronic diseases, pharmacy benefits and formulary review. Specific areas of focus and activities are included in Section C of this narrative.

Section 2713- Coverage of Preventive Health Services

OHIC's current form review process has unearthed a series of challenges that will be further examined in-depth using federal grant funds. OHIC has encountered challenges in applying both state and federal requirements around preventive services as well as defining coverage parameters to better determine what constitutes a preventive service with no cost-share. The following are select *examples* of potential conflict as to what and how an issuer assures no cost-share coverage for preventive services listed in the USPSTF recommendations.

- Screenings: any preventive service description listed as a screening raises questions as to how an issuer is defining a screening, the extent of a screening, and what providers are being reimbursed for screenings that have no consumer cost-shares.
- The USPSTF recommends screening for syphilis infection in persons who are at an increased risk for infection. Determining the scope and parameters an issuer is using to determine what constitutes increased risk of infection is critical to assuring the coverage of preventive services with no cost-shares.

- The USPSTF recommends screening for high blood pressure in adults aged 18 years or older and further recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment. How is this achieved and what services are paid for without cost-share outside of the clinical setting?

These are a few examples of the need for not only drilling down what the USPSTF has defined as "preventive" but also the need for seeking issuer baselines for coverage and the preventive standard of care around such services. OHIC is proposing to use this funding opportunity to address these challenges. Specific proposed activities related to this market reform are included in Section C of this project narrative.

Section 2719- Appeals Process

Rhode Island has a state Utilization Review (UR) statute (RIGL 23-17.12) governing medical necessity decisions made by carriers as well as specifications around internal and external appeals processes dating for over 15 years. Though this UR statute and jurisdiction lies within the RI Department of Health (DOH), there is a need to coordinate this work between OHIC and DOH given OHIC's jurisdiction over the fully-insured market and OHIC's work in interfacing local RI-specific statutes with the requirements of the ACA and the NAIC model act.

There are a number of areas where Rhode Island's state appeals processes are in conflict with the ACA and NAIC Uniform Model Act requirements. For example, the state appeals process requires that two levels of internal appeal be completed before an external appeal can be requested. However, the NAIC Uniform Model Act and ACA allow an issuer to waive the exhaustion requirement, and in cases of expedited review, appellants may file an internal appeal simultaneously with an external appeal. Additionally, the timeframe to request an external appeal is shorter for Rhode Island and the cost associated with an external appeal differs. Using

these grant funds, OHIC will work to align Rhode Island's internal and external appeals processes with the ACA and NAIC standards and will require the most protective standard where there are differences. Specific proposed activities related to this market reform are included in Section C of this project narrative.

Section 2726- Parity in Mental Health and Substance Use Disorder Benefits

In January 2015, OHIC had issued a warrant to begin the process of examining mental health and substance use parity under its market conduct authority. In order to ensure that issuers are not imposing less favorable benefit limitations on the mental health and substance use disorder (MH/SUD) benefits as compared to those medical/surgical benefits, OHIC had begun the process of reviewing, in detail, coverage documents for exclusionary language. During the course of this review, we had found it necessary to also review issuer procedural and policy documents in order to determine obstacles to accessing covered benefits in a timely manner and parity with how medical and surgical services are obtained and paid. OHIC had also determined that reimbursement parity, cost-share parity and parity of formulary as well as access to formulary drugs needs to be assessed. However, due to substantial budget and staffing cuts, OHIC had to suspend its mental health market conduct exam on June 27, 2016. There is significant interagency and stakeholder/community interest in the continuation of this market conduct exam. OHIC is proposing to use federal funds to enhance and continue its review of parity in mental health and substance use disorder benefits. Specific activities are proposed in Section C.

C. Proposed Activities for Planning and/or Implementing Market Reforms

Section 2707 – Non-Discrimination under Comprehensive Health Insurance Coverage

As discussed in Section B, OHIC currently examines compliance with the non-discrimination provisions but is proposing to use this grant opportunity to review plan designs in addition to carrier development of plan designs at a more detailed level. Below are two examples of focus areas with regards to non-discrimination that OHIC will examine with this grant funding:

1. Hepatitis C (Hep C) Treatment. Currently, there are inconsistencies around requirements for issuer treatment of Hep C - issuers are treating Hep C at the later stages of disease whereas treatments for other chronic or acute diseases are covered upon diagnosis. Using grant funds, OHIC will be examining forms, exploring the cost-benefit analysis of treating Hep C at earlier versus later stages of disease, performing a legal analysis on discrimination, working with other state agencies on an aligned approach, and comparing the results of this work to that of other chronic diseases processes, e.g. multiple sclerosis or other "curable" cancers.
2. Potentially Discriminatory Tiered Placement of Medications: In the course of its review, OHIC has identified the potential placement of medications at a high cost-share tier for conditions that are either chronic and/or impact a particular group of individuals. Using grant funds, we would collect data, specific cases, and issuer policies for review in order to better define this issue and enforce non-discrimination rules. This work would also include using tools (e.g. available CCIIO tools) to conduct formulary review. OHIC will engage a clinical pharmacist consultant to examine additional formulary extracts and perform a detailed review and evaluation of any discriminatory exclusions, tier placement or barriers to access to prescriptions drugs. OHIC would also specifically examine potential obstacles to receiving these pharmaceuticals for select groups of chronically ill patients. Potential obstacles could include inappropriate use of utilization review or other issuer protocols that kick-in prior to accessing certain formulary drugs. Specific examples of medications include suboxone and

Lyme disease medications.

3. For the additional funding, OHIC has chosen to expand the scope of same activity. With the addition of supporting staff and contracting monies, OHIC will utilize information from plan management binder assessments and limited All Payer Claims Database (APCD) data to analyze and determine outliers of formulary coverages. OHIC will organize data, with the expertise of a pharmacy consultant to determine other areas of potential discrimination (e.g. smoking cessation).

In addition to these focus areas, OHIC proposes three specific activities under this market reform provision:

1. OHIC will review plan designs for potential discriminatory practices in not covering services for a particular group of conditions/diseases or for sub-groups of individuals. OHIC will request and review issuer claims data on selected chronic diseases and health conditions as well as on high-cost medical conditions. As applicable or appropriate, OHIC will work to incorporate data from the APCD, plan management binder assessments, Department of Health quarterly health plan/utilization review reporting and carrier denial data into this review. Specifically, OHIC will review:
    - Coverage and benefit information,
    - Issuer utilization review processes,
    - Issuer care management processes,
    - Provider networking, credentialing criteria and carrier practices narrowing those who can treat certain chronic or high cost conditions,
    - Reimbursement and consumer cost shares,
    - Claims policies around chronic or high-cost conditions, including Hepatitis C,

- Consumer and provider complaints, and
- Denial and appeals.

This activity will include hiring an analytical consultant, such as a health economist, with expertise in reimbursement equity. Based on the findings and review which are anticipated to be completed in June 2017, OHIC will issue a set of requirements to the issuers on accepted coverage and coverage practices and will incorporate these requirements into our annual form and rate review for the individual and small group market, starting in 2018 (for plans effective 2019).

2. OHIC will conduct a review of existing tools used to identify discriminatory formulary design, including examining existing CMS tools (e.g. the Non-Discrimination Formulary Clinical Appropriateness and Formulary Outlier Tools) and design a RI-specific review tool and procedures for use by form filers and/or contracted experts (e.g. a clinical pharmacist). OHIC will then use these tools to review formulary data from issuers and review all current drug policies and procedures to assess the need for issuer guidance and/or requirements around drug policy and formulary design to meet ACA criteria on benefit design and access to formulary drugs. This work will include examining any associated discriminatory behavior relative to the development of formularies, modification of formularies, tiered formularies and discrimination based (but not limited to) on age, gender or medical condition. This review will involve the hiring of a pharmacy consultant with knowledge of prescription drug coverage and formulary placement.

   Based on the findings and review which are anticipated to be completed in December 2017, OHIC will issue a set of requirements to the issuers on accepted coverage and coverage practices and will incorporate these requirements into our annual form and rate review for the

individual and small group market, starting in 2018 (for plans effective 2019).

3. OHIC will design review tools for use in form review to identify, on an ongoing basis, discriminatory behavior of a carrier in terms of coverage and/or rates. OHIC will utilize this tool for the review of plans effective in 2019.
4. The use of a communications contractor is enhanced with additional funding. Fundamental to performing all the noted activities is to be able to reach out to other states and national counterparts for support and information. In addition, support to develop stakeholder and consumer education and communication tools will be needed.

Section 2713- Coverage of Preventive Health Services

As discussed in Section B, OHIC's current review has uncovered some potential conflict as to what and how an issuer assures no cost-share coverage for preventive services listed in the USPSTF recommendations. Using these grant funds, OHIC will address these potential conflicts in addition to addressing these preventive guidelines relative to the effects of deductibles on preventive services. For example, OHIC will examine potential adverse effects as related to prenatal care. There are a number of USPSTF preventive no cost-share services required for pregnant women. However, issuers may not separate out these preventive services from a global maternity reimbursement which potentially impacts federal and state preventive cost share requirements. OHIC would also like to examine the impact of provider network tiering on compliance with state and federal preventive cost-share guidelines.

OHIC proposes focusing on the following activities under this market reform/consumer protection category:

1. Determine the status of current issuer coverage as well as best practices around preventive medicine in order to better define what the USPTF considers to be preventive. OHIC will use the Communications contractor to design and develop outreach to consumers and providers on best practices and cost share guidelines. OHIC will also utilize the pharmacy consultant to review plan formularies to evaluate coverage for preventive services such as smoking cessation. OHIC will create a baseline preventive coverage table which interfaces state and federal rules and will include establishing the current status for each listed services item and any applicable limitation affecting cost shares. This activity includes communication with all stakeholders involved in form review, including providers, consumers, state/federal agencies, and issuers.

   After the completion of this baseline examination, OHIC will design a set of questions for issuers regarding coverage of these services and comparable questions for the delivery system/providers in order to establish an accurate preventive coverage baseline in Rhode Island for the services categories presented by the USPTF. OHIC will then incorporate this set of questions as part of the form review instructions and will use assessment tools for the annual form review period in 2017 for plans effective 2018.
2. OHIC will review issuer form filings submitted in 2017 (effective 2018) for the information listed in Activity 1 under this market reform section. Form reviewers will review issuer responses to the preventive questions by completing all related tools and templates developed by OHIC in order to substantiate these responses. Form reviewers will also review coverage documents and issuer policies and procedures for compliance and will summarize the status of preventive coverage as submitted as part of the issuer's response. This review will happen in spring of 2017 for plans effective 2018.

3. Once the review process has been completed, OHIC will compile and assess the responses from the 2017 form review process to determine the types of detailed requirements that should exist around preventive coverage plan design that is consistent with both federal and state requirements and OHIC's interpretation of such requirements. OHIC will use tools and/or templates to assess these coverage requirements and will also solicit stakeholder feedback on this work. Once the review and compilation process has been completed, OHIC will issue a notice to issuers in fall 2017 on requirements for plan designs effective in 2019.
4. All preventive plan design coverage requirements and any associated assessment tools and/or templates will be incorporated into the individual and small group form review instructions and SERFF process for plans effective in 2019.These instructions are released to carriers in February/March of 2018 for 2019 plans.
5. Form reviewers will use information submitted by issuers in their filings and review coverage and compliance with preventive plan designs, using coverage documents and issuer policies and procedures. Reviewers will also complete all related tools and templates used to substantiate these responses. All issuers are expected to substantiate full compliance with these OHIC issued requirements prior to approval of a plan effective in 2019. This review will be complete in summer of 2018.
6. OHIC will continue to revisit and review the preventive plan design assessments, tools and/or templates each year for any necessary modifications to meet state and federal requirements. In addition, OHIC will monitor and track information from consumer and provider complaints as well as other issues from public and private stakeholders that may impact the need to make such modifications. OHIC will also provide notices on the interpretation of the findings.

7. OHIC will review carrier policies and practices related to effect of diagnostic procedures conducted as part of a preventive visit or service.

Section 2719- Appeals Process

OHIC will use federal grant funds to bring the adverse benefit determination (ABD) process, which includes the internal review process, and external review appeals process up to the federal ACA and NAIC standards by December 31, 2017 through the following activities:

1. OHIC will analyze the state's ABD process, internal appeals, and external appeals requirements to determine specific conflicts and overlap with the ACA and NAIC Uniform Model Act. OHIC will do a comparison between state and federal statutory requirements, regulatory review and appeals processes, timelines, and costs. This work will involve communication with DOH to address the overlap of jurisdiction between OHIC and DOH. During this process OHIC will determine any specific regulatory and/or statutory changes necessary to align the state external appeals process with the federal process. OHIC and DOH will work to draft and enact an integration agreement as the vehicle for a cooperative arrangement to address jurisdictional overlap and coordination of regulatory oversight by July 2017. This work will also include examining best practices from other states. The communication consultant will assist in the outreach to other states and research of bordering state program requirements.
2. By January 2017, OHIC will review the current requirements with the state-designated external appeals agency (Maximus) to determine how to update requirements. This work will also include a review of neighboring states' (e.g. MA, CT, and NH) independent review organizations (IROs) for external appeals. OHIC will conduct interviews with those states to review their selection process and gauge their satisfaction with their contracted IROs. OHIC

will also draft and develop Requests for Proposals for the purchasing/bidding process that will lead to the selection of three external appeal IROs. The communications consultant will assist in developing Requests for Proposals for the IROs and manage communications for the bidding process.

By summer 2017, OHIC will implement the operational process necessary for Rhode Island to manage the adverse benefit determinations process, internal appeals, and external appeals processes – this includes the intake of requests for external appeals and assignment to the external appeals agency on a random basis

Section 2726- Parity in Mental Health and Substance Use Disorder Benefits

As discussed in Section B, OHIC's mental health and substance use ("Behavioral Health") disorder market conduct exam is currently suspended to a lack of funding and staffing resources. In this grant application, OHIC is proposing to use federal funds to enhance and continue its review of parity in Behavioral Health disorder benefits. OHIC will be focusing on determining qualitative and quantitative disparities in the Behavioral Health arena, in addition to verifying and validating issuer parity analyses. OHIC is proposing the following activities market reform:

1. OHIC will conduct a full Behavioral Health market conduct examination of the individual and small group markets in Rhode Island to include, but not be limited to, parity assessment of inpatient, outpatient, residential, intermediate, and pharmaceutical coverage. This will include the examination of any third party vendor performing functions in these areas. OHIC will review and compare the quantitative and non-quantitative limitations placed on Behavioral Health (BH) coverage as compared to medical/surgical coverage in these areas:
    a. Benefit design and benefit coverage documents to include limitations and exclusions.

b. Issuer establishment of financial, quantitative, and qualitative treatment limitations related to BH and related benefits and coverage meeting parity requirements. The pharmacist and economist contractors will be key to vetting these limitations and potential parity issues. The economist to look at quantitative limits and the pharmacist to look at formulary issues that are not in parity with medical surgical services.

c. Standards and procedures for BH and medical/surgical provider admission to participate in a network.

d. Claims administration functions for BH and related claims, including, utilization management/review, prospective, concurrent and retrospective review programs. medical necessity policies, procedures and criteria, and case management.

e. Fee schedules and other payment methodologies for BH services and for medical/surgical services. This will include looking at primary care cost-shares versus BH cost shares at the outpatient level in terms of parity. OHIC will engage the health economist consultant to analyze provider reimbursement for parity between BH and medical/surgical services.

f. Other financial limitations and quantitative or non-quantitative treatment limitations in connection with BH and related benefits, coverage and claims.

g. Contracts, agreements, protocols, delegations, or any other written material that govern, guide, or are used by the issuer and any third party vendors for BH and related benefits, coverage and claims administration.

h. Consumer inquiries and complaints: policies, procedures and case reviews.

i. Denials, and appeal of claims policies, procedures and statistically significant consumer denial and appeal case reviews.

j. Consumer and provider parity notifications.

k. Consumer and provider notifications denial, appeals and complaints.

l. Identify any delivery system gaps and disconnects contributing to compliance with mental health parity. This will involve working with other state agencies including Department of Human Services, Department of Health, Department of Children, Youth and Families and the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals.

During the process of reviewing any non-quantitative treatment limitations (such as prior authorization and other medical management techniques) on BH benefits, OHIC will request written documentation from the issuer of the processes, strategies, evidentiary standards, and other factors used to develop non-quantitative treatment limitations (NQTLs) for medical/surgical and BH benefits to assure that the factors used in applying the limitation to BH benefits in the classification are comparable to, and applied no more stringently than, those used in applying the limitation to medical/surgical benefits in the classification. OHIC will also assure that the MHPAEA transparency standards are met and are made publicly available according to state and federal rules. The contracted Communications vendor will assist the design and outreach to achieve effective public notification.

OHIC anticipates completing this review and issuing a report by summer 2018. This report will be publicly disseminated once the Commissioner completes her order on the market conduct exam. Based on the findings of the aforementioned market conduct exam and report, OHIC will issue a set of requirements to the issuers on accepted coverage and coverage practices and will incorporate these requirements into the annual form and rate review for the fully-insured market. These requirements will be issued by fall of 2018.

D. Evaluation Plan

OHIC attests that it will comply with the reporting requirements outlined in the grant funding announcement and that it will transmit the required data on a quarterly and annual basis throughout the life of the grant to ensure that milestones are being met and the goal and outcomes of the program are being achieved. OHIC will also comply with any data submission requirements that are revised in the future to reflect changes in regulations or guidance. OHIC's evaluation plan will monitor progress, with measurable outcomes, under the four market reform activities. This plan will ensure that deliverables are achieved on time and on budget and that sufficient structure, work plans, processes, and reporting tools are present to identify and mitigate issues as needed.

Key Indicators to be Measured

The Work Plan identifies the principal tasks and milestones to be completed and achieved within each area and each quarter of the funding period. These tasks and milestones are the project's key indicators to be measured. We will monitor progress toward task completion and achievement of milestones on an ongoing basis. Additional key indicators not mentioned in the work plan include:

- Consumer complaints related to each of the four market reform areas,
- Number of forms/plan designs reviewed in detail for each of the four market reform areas, specific to the activities outlined in this grant.
- Specific to the BH Market Conduct Exam: Baseline information on access, network and non-coverage for BH services as well as denials and appeals data required by the state by calendar quarter and separated by SA, MH and medical place of services.
- Pharmacy formularies as part of all filings and well as denials and appeals data required by the state by quarter specifically for pharmacy services.

Other key indicators may be developed as the grant period progresses.

Baseline Data for Each Indicator

The template below presents the framework to be used in documenting applicable baseline data for each key project task and milestone. This data will provide the starting point from which project progress for each milestone will be measured, through the reports discussed below. This baseline data will be compiled at the initiation of the grant period and each project, as applicable.

Indicator	Project Lead	Baseline

Methods to Monitor Progress and Evaluate the Achievement of Program Goals

Project task and milestone progress is currently monitored by the Operations Director as well as in quarterly reporting to HHS. OHIC will solicit input from the parties responsible for specific tasks and milestones. The evaluation process will include the following four elements:

1. Project Status Reports**:** Project status reports will focus in greater detail on which key tasks and milestones have been completed on schedule, those running behind schedule, and the mitigation strategy for those likely to miss the original scheduled completion date. For each key task and milestone likely to be late, a mitigation strategy will be identified, defining specific actions to be taken to assure completion in a timeframe that does not compromise other tasks and milestones. The project leads will be responsible for overseeing task completion and mitigation strategy implementation for their respective projects.
2. Deliverables Review**:** A detailed deliverables review process has been implemented in order to assure the timeliness, accuracy, and completeness of project deliverables. Deliverable items will be reconciled with the Budget and Work Plan on an ongoing basis. The project team is committed to producing and receiving high-quality deliverables from both internal and external sources. We will continue to follow this approach, focusing on quality improvement, taking

into account the premium placed on the time and resources of project staff, as well as that of other stakeholders and consultants. The deliverables' content, schedule, presentation, tracking, and approval process will be agreed to in advance, with project staff, stakeholders, and consultants agreeing on the specific content, format, and criteria for all deliverables.

3. Communication between Project Staff and Stakeholders**:** An effective communications plan, to support both internal and external communications, is a key component of the project team's method to ensure effective progress monitoring and achievement of program goals. For external communications, we have established a structured stakeholder effort through our Health Insurance Advisory Council. For internal communications among project staff, tasks are managed through meetings and informal communications.

4. Timely Interventions When Targets are Not Met or Unexpected Obstacles Delay Plans: The Project Director will lead the effort in monitoring tasks, milestones, and overall goal progress. The principal tools for monitoring project performance will be the progress reports noted above, coupled with frequent communication between project staff, stakeholders, and consultants. The most effective risk management strategy is risk avoidance. Consequently, our management team asks the following key questions of all parties responsible for project activities and tasks on an ongoing basis:

    a. Is the task scope being managed and assigned effectively?

    b. Are we meeting our schedule?

    c. Are deliverables completed consistent with quality standards?

    d. Are risks and issues managed appropriately?

    e. Is the project meeting all contractual requirements?

f. Are stakeholders, including HHS, satisfied?

This ongoing communication enables us to identify the need for interventions in a timely manner or unexpected circumstances that may cause delay in task completion or milestone achievement. We will track issues and monitor, on an ongoing basis, the issues opened, closed, and pending each month and their relative priority and severity. The template below provides a Sample Issues Management List as an example of the type of tracking sheet we will use to monitor issues, as well as the status of key tasks and milestones—both completed and outstanding.

Project Lead	**Task Milestone/ Deliverable**	**Due Date**	**Revised Due Date**	**Problem**	**Mitigation**	**Status**

E. Commitment to Mentor States

OHIC agrees to mentor states that are in the process of planning and/or the implementation of market reform activities and best practices. OHIC will take every opportunity to share assessment tools and templates with other states either directly or through its NAIC and federal agency contacts.