



July 5, 2012

Centers for Medicare & Medicaid Services  
Department of Health and Human Services

**Attention: CMS-9965-P**

<http://www.regulations.gov>

Thank you for the opportunity to comment on the proposed rule for “Data Collection to Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans,” published in the June 5, 2012 *Federal Register*. This proposed rule includes important provisions for ensuring that Exchange plans meet essential quality requirements and giving consumers information to identify high-value plans. We support your overall approach and offer the following comments on specific issues and requests for comments.

**Two-phased Approach for Recognizing Accrediting Entities:** We agree that the proposed two-phased approach for recognizing accrediting entities is necessary to meet early 2013 Exchange QHP certification needs. We greatly appreciate your proposal to include NCQA in phase 1 and will fully align our Exchange module with final Exchange accreditation rules. It is essential, however, that any recognized accreditation entity use standards and quality metrics that let consumers, regulators and other stakeholders make apples-to-apples comparisons, regardless of which accreditor a plan uses.

We also support your proposal for a phase 2 recognition process with an application procedure, standards for recognition, a criteria-based review of applications, public participation, and public notice of the recognition. For phase 2, we recommend rigorous standards so accreditation assures that the infrastructure and systems are in place for plans to provide high quality care, consumer protection and service. We also urge you to periodically update the criteria to reflect care delivery innovations that improve health care value.

**NCQA Health Plan Accreditation:** The National Committee for Quality Assurance is a non-profit organization that for more than 20 years has worked to improve the quality and value of health care through measurement, transparency and accountability. Our “Gold Standard” Health Plan Accreditation is by far the most rigorous and widely used program for ensuring and improving health plan quality. Nearly 500 health plans with more than 107 million enrollees have earned NCQA Accreditation.

NCQA Accreditation closely aligns with State Health Insurance Exchange plan requirements. These include access to care, utilization management, quality assurance, provider credentialing, handling of complaints and appeals, network adequacy and access, patient information programs, and evaluation on clinical and patient experience measures. NCQA scores plans on audited HEDIS® clinical quality measures and CAHPS® patient experience measures.<sup>1</sup>

We accredit and report performance by both health plan products (HMO, HMO/POS, and PPO) and product lines (Commercial, Medicare and Medicaid, and now Exchange) and by state. We score results to accredit plans as Denied, Provisional, Accredited, Commendable or Excellent. We also publicly report accreditation results to allow direct comparisons among plans. That allows consumers and other purchasers to hold plans accountable and promotes continuous improvement.

**Changes to NCQA's Accreditation Program:** We update our standards annually based on input and consensus among consumers, providers, public and private purchasers, insurers and quality researchers. The annual updating process includes public comment and review by several multi-stakeholder committees that include consumer, employer, public sector and health plan experts. This periodic updating ensures that our program keeps pace with the ever-changing health care landscape and challenges health plans to further improve quality. For example, we are increasing the weight given to performance measures so they have greater influence on plan accreditation scores in 2013. We are adding standards to our Medicaid accreditation program on helping adults manage their own health. We also are looking for ways to incorporate innovative purchasing initiatives and other strategies that have potential to improve value. We generally give plans at least one year notice before changes take effect so they can prepare for them.

We spent the past year updating our accreditation program specifically with Exchange health plans mind. We are adding an Exchange product line to our existing accreditation for plans serving Commercial, Medicare and Medicaid populations. Our goal is to make it as efficient as possible for new plans, like CO-OPs, to become accredited and for already accredited plans to qualify to participate in Exchanges. We also want to maintain our high standards for the program and add HEDIS and CAHPS performance measures to Exchange accreditation scoring as soon as those results are sufficiently valid and robust for benchmarking in Exchange populations. We also are adding different survey evaluation options that plans can pursue, depending on whether they are currently accredited, established plans that we have not accredited, or brand new plans.

*NCQA-Accredited Issuers:* For plans that currently have NCQA Accreditation for Medicaid, Commercial, or Medicare products, we will extend that accreditation to their Exchange offering if they demonstrate that they are running the Exchange product in the same way as their currently accredited product (referred to as an Exchange Add-on).

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<sup>1</sup> HEDIS® - the Healthcare Effectiveness Data and Information Set - is a registered trademark of NCQA. CAHPS® - the Consumer Assessment of Healthcare Providers and Systems - is a registered trademark of the Agency for Healthcare Research and Quality, which oversees the survey.

This add-on will last until the existing accreditation, which plans must renew on a three-year cycle, expires. Plans that will run Exchange products differently from currently accredited products can undergo a streamlined review process to add an Exchange product to their existing NCQA accreditation until it expires.

*Established, Unaccredited Issuers:* Issuers that want to participate in Exchanges should bring an existing plan that is closest to the type they want to offer in an Exchange to NCQA for accreditation now. For example, if they want to offer a PPO in an Exchange, they should have a Commercial, Medicare or Medicaid PPO accredited now. Once that product is NCQA accredited and the plan demonstrates that it is operating the Exchange product in the same way, we will count that status for the remainder of the three-year accreditation cycle toward Exchange accreditation.

*Brand New Issuers:* Newly operating plans like CO-OPs may want to consider our new Interim accreditation program, available to new plans for Exchanges or any other payers as of July 1, 2013. This program includes review of policies, procedures and other essential core structural elements. It recognizes that a new plan will not be able to show the application of those policies and procedures in operation or the ability to report valid quality measures. The Interim survey accreditation is good for 18 months, at which time the organization must go through the First Survey to maintain accreditation. The table below lays out NCQA’s Health Plan Accreditation survey types for 2013.

<b>NCQA Glide Path for Accrediting Health Insurance Exchange Qualified Health Plan Issuers</b>					
<b>Survey Type</b>	<b>Eligibility</b>	<b>Accreditation Status</b>	<b>Duration</b>	<b>Documentation Reviewed</b>	<b>Measures Reporting</b>
<b>Interim</b>	<b>Plans new to NCQA (i.e. Co-ops)</b>	<b>Denied (not public), Interim</b>	<b>18 months</b>	<b>Policy and Procedures</b>	<b>Not required</b>
<b>First</b>	<b>Plans Not Previously Accredited by NCQA</b>	<b>Denied (not public), Provisional, Accredited</b>	<b>36 months</b>	<b>Policy and Procedures &amp; evidence of implementation</b>	<b>Required during 3<sup>rd</sup> year but can be scored anytime</b>
<b>Renewal</b>	<b>Plans with NCQA Accreditation</b>	<b>Denied (public), Provisional, Accredited, Commendable, Excellent</b>	<b>36 months</b>	<b>Policy and Procedures &amp; evidence of implementation</b>	<b>Required and scored every year</b>

**Health Plan Accreditation and Exchange Clinical Quality Measures:** For all survey evaluation options, we have revised our HEDIS and CAHPS reporting requirements for issuers seeking Exchange Accreditation.

We will not score Exchange plans on HEDIS or CAHPS results until 2016 at the earliest for several reasons:

- The first valid, robust clinical Exchange quality data will not be available until June 2015 because plans need at least one complete year to accurately measure their quality performance. For example, Exchange plans will first enroll members from January 1, 2014 to December 31, 2014. Starting in 2015, they will first be able to collect 2014 quality data and then report it to NCQA in June of that year. Only then will we be able to establish benchmarks for scoring in 2016.
- Some measures require more than one year to fairly measure whether a plan has met guidelines for appropriate care. For example, breast cancer screenings are recommended every two years, and we calculate our measure accordingly.
- Some Exchange plans may have limited enrollment that is too small in the first few years for quality measures to be statistically valid. This is most likely for measures of things that occur less frequently, such as "Follow-up after Hospitalization for Mental Illness," than more common issues, like care for diabetics.

Because Exchange plans will not initially be able to report valid performance measures, we will not be able to give them accreditation status of "Commendable" or "Excellent." Instead, in order to ensure a level playing field, we will cap all Exchange product line accreditations, including those using the Interim option, at the "Accredited" status until these plans can report valid performance measures.

Although NCQA does not plan to score Exchange plan HEDIS and CAHPS results until 2016, NCQA can begin collecting Exchange these data from plans in 2015, independent of accreditation. NCQA will encourage plans to report their Exchange HEDIS and CAHPS results, so that we can build benchmarks for analyzing Exchange plan performance at national and regional levels. Building the quality database will also help CMS, state Exchanges and others understand the new Exchange population.

After analyzing the first year of Exchange HEDIS and CAHPS data, NCQA will recommend whether and what measures to score in Exchange Accreditation as early as 2016. If measures are not ready to be scored in Accreditation (for example, due to extreme variability in which more than 50% of plans could not report valid measure results) then NCQA will consider alternatives, such as requiring that Exchange plans report HEDIS and CAHPS results, but not scoring the results in accreditation.

**Quality Measures Included in Accreditation:** Overall, NCQA plans to align the clinical quality and patient experience measures scored in accreditation with any federal requirements. As CMS continues to release rules and guidance on quality measures, NCQA will consider incorporating those components into accreditation as part of our annual updates. For example, measures included in the quality rating methodology could be added to accreditation. For First and Renewal Exchange accreditation, NCQA will incorporate a set of measures based on the HEDIS and CAHPS currently scored in Health Plan Accreditation for Commercial and Medicaid plans. (See attachment A for list of HEDIS and CAHPS measures currently scored in Accreditation).

When recommending measures, NCQA will consider whether Exchange plans are likely to have sufficient enrollment for valid reporting. We will also consider the measure specifications to see when the collection for the Exchange population is feasible in 2015 or 2016. NCQA will release a proposed measures set of HEDIS, CAHPS and other Exchange measures for public comment in 2013.

**Criteria for Quality Measures in Accreditation:** We agree with your proposal that quality measures incorporated into accreditation meet the following criteria:

- Span a breadth of conditions and domains,
- Include separate measures for adults and children,
- Align with both National Strategy for Quality Improvement and National Quality Strategy priorities,
- Include only measures either developed or adopted by a voluntary consensus standards setting body or, where endorsed measures are unavailable, are in common use, and
- Are evidence based.

All measures that we currently score for Accreditation meet these criteria, as will any measures that we score or require for Exchange accreditation.

An additional essential criterion for quality measures is requiring independent auditing of results. Auditing ensures the accuracy and comparability of results and provides an important feedback loop for plans, especially in the early years of reporting.

**Accreditation by Product Type Exceptions:** We generally accredit by product type, which combines product line (i.e. Commercial, Medicare, Medicaid or Exchange) with product (i.e., HMO, POS or PPO). However, we do make exceptions. For example, issuers can combine HMO and POS products for HEDIS reporting purposes. If an issuer wants to combine HMO and PPO or POS and PPO (or all three) it needs our approval. If a plan lacks the minimum threshold of 15,000 members needed for statistically valid HEDIS and CAHPS results it can combine the same product across contiguous states. However, we do not allow product line combinations because of substantial differences in populations served and quality measures specific to these different populations.

**Accreditation of QHP Issuers:** We recognize the importance of having qualified accrediting bodies with experience in performance-based accreditation working to support the success of health insurance exchanges. Our extensive experience at state and federal levels as a deemed accreditor demonstrates our ability to support regulators and plans in the compliance process and achieve our mission of improving quality. There are two functions noted in the proposed rule related to recognizing accreditors for the purpose of the QHP process. We offer our recommendations on these below.

Deeming of accredited plans for certain Medicare Advantage requirements may provide useful examples for the phase II accreditor recognition process. The specific criteria are in 42 CFR §422.158: *Procedures for approval of accreditation as a basis for deeming compliance*. Accreditors must submit an application demonstrating their capacity to review plans.

CMS reviews deemed status every six years and posts both applications and outcomes in the *Federal Register*. Each year, NCQA gives CMS a crosswalk of our accreditation standards to document alignment with deemed Medicare Advantage requirements. CMS reviews this crosswalk to verify that our requirements are equivalent to CMS' requirements.

**Network adequacy:** Assuring network adequacy is an important piece of the Exchange plan qualification process. Our accreditation program reviews whether issuers' policies and procedures include measurable standards for the number of each type of providers, including primary, specialty and behavioral health care. We also look at whether plans are analyzing performance against their defined standards.

To assist in reviewing network adequacy and minimize documentation requirements, CMS may want to collect NCQA data on plan performance on these requirements. NCQA can include how plans score on some network adequacy elements in accreditation data files we provide to CMS. For example, we can report a plan's score on NCQA QI 4: Element B: Practitioners Providing Primary Care (The organization establishes and annually analyzes performance against quantifiable and measurable standards for the number and geographic distribution of primary care providers). This scoring information can support CMS network adequacy review. NCQA would not be able to provide any other information beyond the scoring, but would encourage CMS to work with plans if further review or information is desired.

We also note that the proposed rule may require the network adequacy assessment to include essential community providers. This is something we should be able to do, and if needed we look forward to working with you to address this issue in a timely manner.

**Accreditor Data Sharing Requirements:** We support requiring accreditors to submit documentation, including accreditation standards, requirements, processes, and specifications for performance measures. Such transparency is a cornerstone of NCQA's commitment to accountability, and we are happy to provide this documentation at any time you require. We are also pleased to submit proposed changes or updates with 60 days notice before implementation to allow ample opportunity to ensure that our program continues to meet your requirements. We are further pleased, when authorized by QHP issuers, to enter into data use agreements with CMS to provide accreditation survey data elements. These elements are the QHP issuers' name, address, Health Insurance Oversight System (HIOS) and unique accreditation identifier(s), accredited product line(s) and type(s), accreditation status, survey type or level and expiration date, and clinical quality and adult and child CAHPS measure results and expiration dates of these data.

We look forward to working with CMS to define the process for providing data and data elements. Items in need of further discussion include:

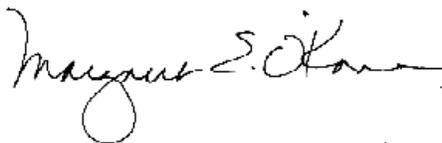
- Definition of the HIOS ID, so we can incorporate it into our systems to allow more efficient data sharing.
- Understand how CMS will use the data, for example for plan oversight and monitoring or public reporting.

- Whether NCQA can collect authorizations from issuers to release data elements to CMS.
- Clarification of accreditation status vs. score. NCQA defines accreditation status as Excellent, Commendable, Accredited, Provisional or Denied. We define score as a number of points out of 100. We also need clarification of whether score means individual standard scores (all standards or a subset, for example for network adequacy) or a total score for all of accreditation. (Other accreditors may not derive a portion of their score off of relative clinical performance and member experience as we do.)
- What clinical quality and CAHPS measure results data must be reported (e.g., numerators and denominators only or more detailed data like member-level survey results).
- Whether accreditors must provide accreditation data on non-Exchange products (Commercial, Medicaid or Medicare) during early years of the Exchange. Existing issuers that come into Exchanges may have measures for other populations, such as commercial, Medicare or Medicaid enrollees. HEDIS and CAHPS results can differ substantially across an issuer's product lines. Measurement results for issuers' existing Medicare, Medicaid or Commercial populations may not reliably reflect results for Exchange enrollees served by the same issuer.
- What is meant by, "at the level defined by the Exchange (for example, QHP product or plan level)." There should be sufficient numbers for valid data collection by issuers, but not necessarily at the plan (Bronze, Silver, Gold or Platinum) level.

We look forward to clarifying these points to ensure that the final rule's burden and cost estimates are accurate.

Thank you again for recognizing NCQA as an accreditor and the opportunity to comment on this rule. Please contact our Vice President for Public Policy and Communication, Sarah Thomas, at (202) 955-1705 if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Margaret S. O'Kane". The signature is fluid and cursive, with a large initial 'M' and 'O'.

Margaret O'Kane,  
President

**HEDIS and CAHPS Measures Scored in Health Plan Accreditation 2012 for  
Commercial and Medicaid Product Lines - Potential Measures for Exchange Accreditation**

<b>Measure</b>	<b>Data Collection Method</b>	<b>Commercial</b>	<b>Medicaid</b>
Antidepressant Medication Management (Both Rates)	Admin Only	✓	✓
Appropriate Testing for Children With Pharyngitis	Admin Only	✓	✓
Appropriate Treatment for Children With Upper Respiratory Infection	Admin Only	✓	✓
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Admin Only	✓	✓
Breast Cancer Screening	Admin Only	✓	✓
Cervical Cancer Screening	Hybrid for Medicaid, Admin Only for commercial	✓	✓
Childhood Immunization Status (Combination 2)	Hybrid	✓	✓
Chlamydia Screening in Women (Total rate)	Admin Only	✓	✓
Cholesterol Management for Patients With Cardiovascular Conditions (LDL-C Screening Only)	Hybrid	✓	✓
Colorectal Cancer Screening	Hybrid	✓	
Comprehensive Diabetes Care (Eye Exam, LDL-C Screening, HbA1c Testing, Medical Attention for Nephropathy)	Hybrid	✓	✓
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%) *	Hybrid	✓	✓
Controlling High Blood Pressure	Hybrid Only	✓	✓
Flu Shots for Adults (Ages 50–64)	Survey	✓	
Follow-Up After Hospitalization for Mental Illness (7-Day Rate Only)	Admin Only	✓	✓
Follow-Up for Children Prescribed ADHD Medication (Both Rates)	Admin Only	✓	✓
Medical Assistance With Smoking and Tobacco Use Cessation (Advising Smokers and Tobacco Users to Quit Only)	Survey	✓	✓
Persistence of Beta-Blocker Treatment After a Heart Attack	Admin Only	✓	
Prenatal and Postpartum Care (Both Rates)	Hybrid	✓	✓
Use of Appropriate Medications for People With Asthma (Total Rate)	Admin Only	✓	✓
Use of Imaging Studies for Low Back Pain	Admin Only	✓	✓
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	Admin Only	✓	✓