June 29, 2015

Andrew M. Slavitt, Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-2390-P

Dear Administrator Slavitt:

Thank you for the opportunity to comment on the modernization of Medicaid and CHIP Managed Care regulations. The National Committee for Quality Assurance (NCQA) strongly supports this transition, which parallels our 25 years of work on improving the quality and value of health care. We believe that alignment of the rules governing Medicaid with other sources of coverage, such as Qualified Health Plans and Medicare Advantage, will benefit consumers and health plans alike. Such a streamlined approach to quality improvement and measurement is critical to managing costs and efficiency. A comprehensive approach to oversight of these programs will also help control costs and improve quality for the millions of eligible Americans who are most in need of better care.

Accreditation, Deeming & Non-Duplication:

Use of Accreditation. We strongly support CMS recognition of the value of accreditation and the standards accreditors use to promote quality. However, we have serious concerns about giving states the option to take national accreditors’ proprietary standards and develop home grown evaluation programs. This approach will not produce a comparable set of results and is not equivalent to a plan undergoing an accreditation review.

We believe it will hamper efforts to standardize the review process and prevent accurate comparisons across plans, across states, and across the country as a whole. If the intent is to promote the use of accreditation standards across all Medicaid Managed Care states, requiring accreditation by a nationally recognized accreditor would not only facilitate a rigorous and proven review process with apples-to-apples comparisons, it would align Medicaid policies with those in the Marketplace where plans must be accredited. It would also minimize administrative burden on states and health plans.

Currently, 17 states require NCQA accreditation for their Medicaid Managed Care (MMC) plans. An additional 16 states recognize NCQA accreditation in the oversight of MMC plans.
**Expanding Deemable Activities.** In further interest of efficiency and alignment, NCQA also strongly supports the expansion of areas eligible for deeming. Deeming validation of performance measures would reduce duplicative work for plans by allowing them to use their HEDIS compliance audit to demonstrate satisfaction of state requirements. Because this submission would be in lieu of state review, it would save the state the time and cost of performing their own review as well as minimize administrative burden on the plans. In addition, we support the expansion of deeming to cover Performance Improvement Projects. NCQA’s performance-based Accreditation relies much more on actual results measured by HEDIS and CAHPS; however, we recognize that some states may need to assess the specific actions that plans are taking to improve quality.

**Network Adequacy.** NCQA supports having states establish time and distance standards for the essential categories of providers as proposed. These include primary care (adult and pediatric); OB/GYN; behavioral health; specialist (adult and pediatric); hospital; pharmacy; pediatric dental; and additional categories as appropriate. However, we also note that time and distance standards have limitations, as they do not address whether clinicians are taking new patients, have available appointments, or deliver quality care. States should take other factors into consideration, including (but not limited to): access to initial and follow-up appointments, member experience, and complaints and appeals related to access issues. Time and distance standards also do not account for non-traditional services such as telemedicine which can improve access, especially in provider shortage areas, to higher quality providers and more appropriate specialists. We therefore believe it is particularly important for states to have flexibility in determining the appropriate standards for access given the specific geographic and provider availability constraints they face.

**Comprehensive Quality Strategy & Rating System:**

**Comprehensive Quality Strategy.** Consistent with the goal of supporting quality improvement for all Medicaid delivery systems, NCQA supports requiring states to develop a comprehensive quality strategy for improving the health of the broader Medicaid population. We believe that state reporting on a standardized set of metrics and performance outcomes to both CMS as well as the general public would help facilitate the transition to value-based purchasing. It would also enable accurate comparisons of quality performance across plans. Defining these measures at the federal level and incorporating them into standardized Performance Improvement Projects will require that states’ contracts with plans continue to focus on driving up quality. It’s also important, however, to ensure alignment between the standards to which we hold both states and their contracted MMC plans.
**Quality Rating System.** In conjunction with the quality strategy, implementation and public reporting of a quality rating system (similar to those used in Medicare Advantage and Marketplace plans) would enable accurate comparisons across plans. Many people who purchase plans in the Marketplace will periodically be eligible for Medicaid, so this alignment would also ease the transition for beneficiaries moving between these coverage options.\(^1\) If states are going to have flexibility in choosing an alternative rating system, it is critical that these alternatives be sufficiently consistent to allow apples-to-apples comparisons for plans across the country. We encourage you also to explore options for allowing performance measurement to follow enrollees as they transition between Marketplace and Medicaid plans, and would value the opportunity to explore this pressing issue with you.

**Beneficiary Protections:**

We strongly support the proposal to harmonize beneficiary protections across Medicare, Medicaid and Marketplace plans. It will empower beneficiaries to make informed decisions about enrollment and limit gaps in coverage due to transitions between programs or shortcomings in administrative and appeal processes. Additionally, incorporation of Long-Term Services and Supports into managed care can promote better quality, cost and experience of care for this vulnerable population.

**Appeals & Grievances.** As part of the broader alignment with other programs like Qualified Health Plans and Medicare Advantage, NCQA supports streamlining the appeals and grievances process. This will assure beneficiaries fair and adequate information regarding coverage denials as well as appropriate timelines for recourse when given such denials. We support the alignment of appeal policies in Medicaid Managed Care with those in Medicare Advantage by defining a 60 day appeal timeline at the federal level. This is much simpler than the current flexibility afforded to states in choosing a timeline between 20-90 days. The rule would provide a more manageable framework for consumers navigating the appeals process; and for organizations managing multi-payer plans, the rule would align protocols across product lines.

The rule also clarifies regulatory language around voluntary and mandatory as well as active and passive enrollment. Like CMS, NCQA believes consumers are the best authority on what care plan is most appropriate for them so we support requiring plans to empower beneficiaries with accurate and timely information about care options. In cases where beneficiaries elect not to actively enroll in a plan, we believe CMS should assure the state’s ability to conduct intelligent default enrollments.

**Continuity of Care.** Affording beneficiaries flexibility when transitioning between plans is also important but we believe mechanisms should be in place to prevent churning in and out of plans. Continuity of care is important for holding plans accountable for those they serve. To that end, NCQA strongly supports transition policies that hold plans accountable and prevent any gaps in coverage when beneficiaries switch between plans. Permitting enrollees to continue to receive services from current providers for a limited period of time after transitioning and referring them to appropriate alternative providers is a critical part of this policy.

\(^1\) Kaiser Health News, [Millions Of Lower-Income People Expected To Shift Between Exchanges And Medicaid](https://www.kaiserhealthnews.org/), January 2014
**Managed Long-Term Services and Supports.** We are also enthusiastic about the potential for quality improvement and cost savings with integration of Long-Term Services and Supports (LTSS) into Medicaid Managed Care. However, we also recognize the risks, and we support the explicit application of managed care oversight provisions to LTSS. We strongly support ensuring access through public reporting of network adequacy, formalizing a mechanism for stakeholder input in future rulemaking, and closing gaps in care related to shortcomings in the administrative process. The rule also requires Managed Long-Term Services and Supports plans to identify potential candidates for these services and produce a treatment plan with their provider. We believe this is an essential part of preventive care and controlling the overall cost of treating this population.

NCQA is currently planning to pilot standards through a learning collaborative for health plans and community-based organizations (CBO) that manage and coordinate care for this population. The goals of this project are to strengthen NCQA’s accreditation standards to specifically address the needs of LTSS users, and to develop an implementation guide for health plans and CBOs seeking to improve their care management processes. Our pilots will also perform self-assessments with the goal of identifying specific areas to improve care. This will enable the collaborative to share experiences, needs, and lessons learned. We plan to publish standards in July 2016 for immediate implementation in our Case Management Accreditation; in July 2017, we will also implement LTSS as a module in our Health Plan Accreditation.

NCQA is also developing a person-centered approach to measuring and delivering quality care for people with LTSS needs. We plan to develop quality measures based on individually-generated goals. Peoples’ goals often address their ability to function, such as being able to play with grandchildren, socialize, walk or garden. We are exploring ways to use these individual goals both as the basis for care planning and for measuring quality to understand how effectively an organization helps its members to achieve their individual goals. NCQA would be happy to discuss this directly with you and get your insights on how this approach – one that brings the individual’s voice into care planning and quality measurement – can support CMS’ quality oversight and delivery system transformation objectives.

**Actuarial Soundness, Rate Setting & Medical Loss Ratio:**

Like CMS, NCQA is concerned with provider payments and their link to ensuring access and value of services. We also believe in holding plans accountable for how they spend their premium revenues and, to that end, establishing requirements for spending on activities directly related to quality of care. We are also encouraged by the new special contract provisions related to payment and the ties with value-based purchasing efforts.
We support actuarial review to guarantee adequate payments for providers to deliver quality care and services to covered populations. Soundness criteria, however, must consider the importance of all aspects of care delivery – not just clinical services alone. This consideration is especially vital for plans treating low income populations as extensive support networks often help identify preventable problems or reduce the downstream need for expensive clinical services. For example, studies show that open access health systems, which often assume the cost of extended clinical hours, are associated with higher rates of detecting colon cancer.²

Medical Loss Ratio: We encourage CMS to adopt a more sensitive approach so that plans, when applying the newly-mandated 85% Medical Loss Ratio, can provide adequate ancillary and non-medical services to support the overall health of their beneficiaries. For example, in states like Mississippi that suffer from long-term excessive heat exposure and 67% of Medicaid beneficiaries are either children or over 65, subsidizing air conditioners can help prevent heat-related hospitalizations.³

Special Contract Provisions Related to Payment. In the interest of furthering value-based purchasing reform, NCQA strongly supports the special contract provisions related to payment that are set forth in the new rule. We believe requiring plans to implement value-based initiatives like those in Medicare will drive up quality while effectively controlling the cost of doing so. We encourage CMS to not just allow states to require plan participation in these initiatives, but also provide incentives for getting states on board with the broader transition from volume to value in health care delivery.

Thank you again for the opportunity to share comments on the proposed rule. Please contact Paul Cotton, Director of Federal Affairs, at cotton@ncqa.org or Kristine Thurston Toppe, Director of State Affairs, at toppe@ncqa.org if you have questions.

Sincerely,

Margaret O’Kane,
President

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² Institute of Health Economics and Management, The Effect of Non-Medical Factors on Variations in the Performance of Colonoscopy Among Different Health Care Settings, August 2009
³ Kaiser Family Foundation, Medicaid Enrollment by Age, State of Mississippi, FY 2011