ACAP
Association for Community Affiliated Plans

1015 15th Street, N.W., Suite 950 | Washington, DC 20005
Tel. 202.204.7508 | Fax 202.204.7517 | www.communityplans.net
John Lovelace, Chairman | Margaret A. Murray, Chief Executive Officer

ACAP Comments on Proposed NCQA 2016 Health Plan Accreditation
April 8, 2015

Network Management (NET)

Network Management (NET): Do you support moving the proposed existing HPA standards to the NET category of standards? Are there other standards that should be included in NET?

Support with Modifications

ACAP generally supports the creation of the proposed network management standards as a separate category. However, as described in our responses to subsequent questions, there are several issues that need to be addressed in the NET standards. First, provider shortages in some specialties in certain geographic areas, specifically psychiatry and some oncology subspecialties, may make it impossible for health plans to meet some of the standards, and the standards must reflect these challenges. Second, health plans should define high-volume specialties based on their member mix and past experience. While obstetrics/gynecology and oncology may be appropriate for some plans, they may not be the appropriate high-volume providers for all plans.

NET 1, Element C: Practitioners Providing Specialty Care (former QI 4C): Do you support including oncology as a required specialty for analysis in Element C? If not, why not?

Do Not Support

Health plans should define high-volume specialties based on their member mix and past experience. Including oncology may make sense for some plans, but it may not make sense for others. Furthermore, ACAP is concerned that the inclusion of "oncologists" does not accurately measure whether health plan members have appropriate access to oncology providers. Unlike obstetrics/gynecology, oncology has many subspecialties. The number of oncologists in a plan's network is not useful if they are not the type of oncologists needed; for example, radiation oncologists and gynecological oncologists are fundamentally different providers, and that is not captured by this measure. No measure can appropriately capture all oncology subspecialties, and any that attempt to do so would be overly administratively burdensome. However, if NCQA decides to include oncology as a required specialty for analysis in Element C, ACAP recommends that it be changed to oncology/hematology.

NET 1, Element D: Practitioners Providing Behavioral Healthcare (formerly QI 4D): Do you support this update?

Support With Modifications

Many health plans already assess availability for the types of practitioners listed in the proposed standards. However, ACAP thinks it is important to recognize that the limited number of MD/DO behavioral health practitioners especially in some geographic areas greatly impacts a plan's ability to include such providers in their networks. Many areas, particularly rural or otherwise underserved regions, do not have practicing psychiatrists, and this challenge must be recognized by NCQA going forward. Additionally, all NET standards, but behavioral health standards in particular, should acknowledge innovative and non-traditional work health plans are

doing to ensure adequate provider networks, particularly through the use of telemedicine. While state regulations about the use of telemedicine vary, providers available through telemedicine are an extension of an insurer's provider network and should be counted as such for the purposes of any network adequacy standards or requirements.

NET 2, Element A: Access to Primary Care (former QI 5A): Do you support this update?
Support
ACAP supports moving the former QI 5A standard to the NET standards.

NET 2, Element B: Access to Behavioral Healthcare (formerly QI 5B): Do you support this update?
Support With Modifications
While ACAP supports measuring access for primary care, behavioral health, and specialty care separately, the time standards for access to behavioral health care, particularly for routine visits, are unrealistic and unnecessary. For psychiatrists in particular, the dearth of providers in many geographic areas does not allow routine visits within 10 business days nor is it always medically necessary to have a routine visit within 10 days of request. ACAP can only support this standard if the time frame for an appointment for a routine visit is lengthened to reflect actual practice and availability.

NET 2, Element C: Access to Specialty Care (NEW): Do you support this update?
Support With Modifications
While ACAP supports measuring access for primary care, behavioral health, and specialty care separately, health plans should define high-volume specialties based on their member mix and past experience. While oncology may be appropriate for some plans, they may not be the appropriate high-volume specialties for all plans.

NET 2, Element C: Access to Specialty Care (NEW): Do you support including oncology as a required specialty for analysis in Element C? If not, why not?
Do Not Support
Health plans should define high-volume specialties based on their member mix and past experience. Including oncology may make sense for some plans, but it may not make sense for others. Furthermore, ACAP is concerned that the inclusion of "oncologists" does not accurately measure whether health plan members have appropriate access to oncology providers. Unlike obstetrics/gynecology, oncology has many subspecialties. The number of oncologists in a plan's network is not useful if they are not the type of oncologists needed; for example, radiation oncologists and gynecological oncologists are fundamentally different providers, and that is not captured by this measure. No measure can appropriately capture all oncology subspecialties, and any that attempt to do so would be overly administratively burdensome. However, if NCQA decides to include oncology as a required specialty for analysis in Element C, ACAP recommends that it be changed to oncology/hematology.

NET 3: Member Experience With the Organization's Network: Do you support evaluating member experience with network providers separately from network experience with health plan services (QI 4)? If not, why not?
Support With Modifications
While we appreciate the intention of NET 3, we have identified several necessary changes. ACAP requests clarification on how member requests for out-of-network services are tracked and defined. ACAP feels strongly that a simple call to a plan's member services department with an inquiry about the network should not be included in this measure; instead, it should reflect only true requests for out-of-network services.

NET 3, Element A: Annual Assessment of Experience with Medical Services and Element B: Annual Assessment of Experience with Behavioral Healthcare Services: Is it feasible for plans to track out-of-network requests for all product lines separately? If not, why not?
Do Not Support
Depending on how out-of-network requests are defined, many health plans do not and cannot easily track such requests by line of business. If such requests include generic inquiries about the plan's network and out-of-network providers to the call center, such tracking by line of business would be difficult for many health plans. However, ACAP does not feel that such questions should be counted as out-of-network requests; instead, only formal requests for out-of-network services should be included. Additionally, tracking such requests by line of business is burdensome for plans with several product lines; thus ACAP recommends that such requests be calculated for each accredited entity instead.

NET 3, Element A: Annual Assessment of Experience with Medical Services and Element B: Annual Assessment of Experience with Behavioral Healthcare Services: Do you support scoring this element by product line and averaging for a final score (i.e., Unit of Analysis) If not, why not?
Do Not Support
As noted in response to the previous question, ACAP believes that this measure should be calculated by accredited entity and not by line of business. However, if NCQA decides to score this element by product line and average the scores for the final score, NCQA should consider whether the average should be weighted by membership. For example, it may not make sense to average the scores for a plan with two lines of business if one product line has significantly more members than another, as is the case for many Medicaid health plans that have recently launched Qualified Health Plans in the health insurance Exchanges.

NET 4, Element A: Medical Opportunities for Improvement (New): Is it feasible for health plans to act on three opportunities to improve network adequacy? If not, what is a reasonable number of opportunities?
Do Not Support
There are limited opportunities to improve network adequacy, particularly for specialties like psychiatry with significant provider shortages in certain geographic areas. Additionally, some

interventions, including establishing a teleconsult or telemedicine program, are expansive and may address multiple regions, specialties, and populations. Because many interventions may cross multiple specialties and multiple identified opportunities, at least initially health plans should only need to implement one intervention, if applicable. Additionally, ACAP requests clarification on whether initiatives already underway can count towards the fulfillment of this request. Many health plans are taking action to strengthen their provider networks.

NET 4, Element A: Medical Opportunities for Improvement (New): Should Element A be split into separate requirements for primary care and specialty care?
Support
ACAP feels that Element A should be split into separate requirements for primary care and specialty care, because they fill different needs for managed care products. However, it should be acknowledged that some opportunities to improve network adequacy may include both primary and specialty care. When this is the case, one intervention that affects both domains should be counted as an intervention for both primary care and specialty care.

NET 4, Element B: Behavioral Healthcare Opportunities for Improvement (former QI 6D): Do you support this update?
Support With Modifications
As mentioned previously, network adequacy around behavioral health is challenging because of the lack of behavioral health providers, particularly psychiatrists, in certain geographic areas. As such, NCQA must recognize that factors outside of the plan's control, including state restrictions on the use of telemedicine, may affect a plan's ability to develop and implement interventions to address behavioral health network adequacy.

NET 7, Elements C: Assessment of Physician Directory Accuracy (New): Are there other directory information fields for which plans should be required to assess accuracy?
Support
ACAP supports the addition of this element. Most ACAP health plans have a web-based provider directory that includes the information listed in the proposed standards. However, it should be noted that despite being contractually obligated to do so, some providers do not alert plans with which they contract when their information or plan participation status changes. While health plans have multiple techniques for ensuring their provider directories are as up-to-date as possible, health plans cannot continuously monitor all contracted physicians to make immediate changes if the plan is not alerted to them by the provider. It should be acknowledged that frequent updates to hard-copy printed provider directories are unrealistic; the moment a paper directory is printed it is out of date. Thus, it is important that any time frames for updates apply only to Web-based directories.

NET 7, Elements D: Identifying and Acting on Opportunities (New): Do you support this update?
Support

ACAP appreciates the intent of this element, as ACAP-member plans strive to maintain accurate and updated provider directories. It must be acknowledged that health plans must rely on providers to tell the plan when their information has changed, and providers frequently fail to relay this information to plans with which they contract. While health plans have multiple techniques for ensuring their provider directories are as up-to-date as possible, health plans cannot continuously monitor all contracted physicians to make immediate changes if the plan is not alerted to them by the provider.

NET 7: Physician and Hospital Directories, Element G, factor 4: Do you support this update?
Support With Modifications
ACAP understands the motivation to include hospital quality data from recognized sources in the Web-based directory. However, we are concerned that recognized sources on hospital quality data are often contradictory. A recent Health Affairs study (Austin et al, National Hospital Ratings Systems Share Few Common Scores And May Generate Confusion Instead Of Clarity, Health Affairs vol. 34 no. 3, March 2015) found significant lack of agreement among national hospital rating systems on whether hospitals were high- or low-quality. We encourage NCQA to think about if and how such information should be presented in a health plan's provider directory, when other data sources, including Medicare's Hospital Compare, are readily available. In addition, when utilizing sources such as Medicare's Hospital Compare, plans should be able to supply a link to the methodology section of that website as a means to meet the requirement.

<u>Utilization Management (UM)</u>
Appropriate Denials Classification UM XX (New): Do you support this update?
Support With Modifications
ACAP generally supports the intent of this update, but requests clarification on the document or reference required. Some health plans found it unclear whether they would be required to provide the full contract during an audit, rather than references to the criterion on which the decision was based.

Appropriate Denials Classification UM XX (New): Should NCQA make this element a must-pass element? If not, why not?
Do Not Support
ACAP feels strongly that new requirements should not be must-pass elements, especially in the early years of implementation. Thus, UM 4 XX should not be a must-pass element.

Timeliness Reports for Denials UM XX (New): Do you support this update?
Support With Modifications

ACAP agrees that it is important to monitor timeliness of UM decision making, but cautions NCQA that for plans with multiple lines of business, creating and maintain such a report may be quite difficult. Because different lines of business have different time frames and different types of categories, combining them into one report is not straightforward. For example as discussed previously, Medicare Part D's expedited process for coverage determination for an exception request begins when the physician submits their supporting statement while the Marketplace timeline begins immediately. Thus, different standards for timeliness and different categories of requests may not easily come together into a single report.

UM 4: Appropriate Professionals, Element B, Use of Practitioners for UM Decisions, factor 2: Do you support this update?
Support
ACAP supports the decision to require practitioners to have a clinical license to practice or an administrative license to review UM cases.

UM 8: Polices for Appeals, Element C: External Reviews in States with Laws: Do you support this update?
Support with Modifications
ACAP supports simplification of this element. Health plans should be allowed to communicate with members in the method in which the members desire, whether that is by mail or electronically.

UM 8: Policies for Appeals, Element B: External Reviews in States without Laws: Do you support this update?
Support
ACAP supports the removal of this element.