ACAP Comments to NCQA
2014 Health Plan Accreditation Standards
Submitted March 18, 2013

The Association for Community Affiliated Plans (ACAP) is a trade association of 58 safety net health plans in 24 states that serve over 9 million Medicaid-enrolled individuals, approximately one-third of the Medicaid lives enrolled in Medicaid Managed Care. Safety net health plans are nonprofit (or owned by a nonprofit) and predominantly serve the publicly insured. In order to foster integrated care management, about one-half of the ACAP plans also operate a Medicare Dual-Eligible Special Needs Plan and/or will be participating in the federal dual eligible demonstration.

ACAP health plans support continued efforts to improve the quality of services provided to individuals enrolled in Medicaid. However, we are concerned about the proliferation of new standards, even though other standards of questionable value that are now superseded by statutory requirements are not being deleted. For example, we question the need for standards related to parity and privacy/security given that both are covered by statute. We also question the need to double the number of opportunities identified in Q10 and Q11. In addition, we question that some additions to the standards associated with the change in MBHO standards are too proscriptive.

With exception to the items listed below, ACAP supports implementing the Member Connection standards but ***advocates for a delay in the effective date until 2016 for Medicaid and Medicare plans (including D-SNPs) with less than 15,000 members.*** However, ***ACAP health plans do not support the implementation of those Member Connection standards related to website functionality (MEM 3A, MEM 4A, MEM 5A, and MEM 6A) available via a member portal.*** For the reasons listed below, ***we strongly advocate that Medicaid health plans and small Medicare health plans (including D-SNPs) be excluded from these requirements.*** Alternatively, at a minimum, we would request that this Element be delayed until 2016.

Individuals enrolled in Medicaid and D- SNP health plans serving the dual eligible population do not have the same need to access claims data that occurs in other commercial plans. Generally, there is little cost-sharing and, where it is exists it is limited to copayments that must be paid at the point of services. Coinsurances are basically non-existent in the Medicaid population and providers are prohibited from any balance billing. In fact, in most states, plans are not required to issue Explanation of Benefits for these very reasons. Therefore, a requirement for a member portal that allows members to check on claims status is not relevant.

Moreover, individuals enrolled in Medicaid move more frequently and change their telephone numbers more often than the general population, as evidenced by the large amounts of returned mail. Oftentimes, the only ability a health plan has to correct addresses and telephone numbers is through information provided when members contact the Member Services areas for services that would potentially be shifted to the Member Portal. In fact, Medicaid health plans are frequently utilizing contact with the Members Services line as an important vehicle for following up on clinical issues such as identified gaps in care. Therefore, limited this opportunity for direct member contact would be an unfortunate by-product of this proposed requirement.

Concerning the ability to do online PCP changes, it would limit the ability of the health plan to utilize the Member Services contact to determine why the member wishes to change PCP. Is it due to a change of address not reflected in the file? Is it because of an inability of the PCP to meet special needs of the members that may have been previously undocumented? Is it because of dissatisfaction with the PCP that should be converted from just a request to change PCP to a formal complaint to allow for follow-up and quality improvement activities?

Finally, Safety Net Health Plans serving the Medicaid population are financed very differently than commercial plans with the rates often set at an artificially low level by the states. In addition, given the non-profit status of the Safety Net Health Plans, there is limited access to capital markets. While the proposal would delay implementation until 2015, it would still coincide with a number of competing IT demands including ICD-10 implementation and CORE Operating

Standards. Therefore, we strongly oppose asking Safety Net Health Plans to make a significant investment for the member portal features that are of limited relevance and may, in fact, hinder the ability to provide high quality care.