ACAP
Association for Community Affiliated Plans

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Sarah Thomas
VP, Public Policy, Communications and Marketing
NCQA
1100 13th St, NW Suite 1000
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Dear Ms. Thomas,

The Association of Community Affiliated Plans (ACAP) is a trade group representing 58 non-profit, safety net health plans in 25 states that serve over 9.5 million publicly insured individuals. ACAP and its health plan members are strong supporters of quality measurement and the public reporting of quality data. The purpose of this letter is to express some concerns regarding the scoring methodology for the NCQA rankings that appear on both the NCQA website and in Consumer Reports. We offer these in the spirit of improving the support of publically reported quality data in health care.

The first concern has to deal with the role of NCQA accreditation in the scoring methodology and the impact it has on public reporting of quality data. In the past, non-accredited health plans that have agreed to publicly report their quality scores to NCQA have been surprised to find the plan ranked extremely low on the NCQA rankings because of the loss of up to 15 points solely due to their non-accredited status. This is true even if the plan is accredited by a competing accrediting body. In most cases, these plans make a rational decision to not publicly report HEDIS scores in future years, since it is better to be included in the group of plans that do not publicly report than to be ranked very low based solely on the fact that they are not NCQA accredited. As a result, the number of publicly reporting plans is diminished even though the health plans support public reporting and would be willing to be ranked fairly based on their score on these measures.

Moreover, Dual Special Needs (D-SNPs) health plans that are not accredited do not always realize that it is optional to publicly report the quality data. This confusion arises because NCQA also serves as a contractor to CMS to provide oversight of SNP activities. Plans do not realize that NCQA is serving multiple roles and that they can refuse to publicly report as part of NCQA Quality Compass and, therefore, be excluded from the health plan rankings, even though they must report to NCQA for the CMS contracted SNP health plan oversight. We ask that this issue be clarified for health plans when they report quality data to NCQA.

Concerning the Medicare rankings as it applies to D-SNPs; there is an additional accreditation issue which impacts the health plan rankings. By definition, D-SNPs are serving individuals who are both Medicaid and Medicare eligible. If a plan is already accredited for their Medicaid line of business and do not serve any other Medicare Advantage population, it makes sense that the plan would not seek separate Medicare accreditation for serving the dual eligible population. However, in the Medicare rankings, the Medicaid accreditation status is not taken into account as part of the scoring methodology, even if the plan is only serving individuals covered by both Medicare and Medicaid. We believe that a plan that functions in the Medicare space solely as a D-SNP should be given credit as part of the scoring methodology if they are accredited for their Medicaid line of business.

NCQA has always taken care to separately report the commercial, Medicaid and Medicare lines of business in recognition of the fact that the populations served by these lines of business are different. D-SNPs are not only serving individuals with lower incomes, but also have a much higher mix of individuals under the age of 65 years of age with permanent disabilities. Moreover, enrollment processes for D-SNPs differ from other Medicare Advantage plans because members can disenroll on a monthly basis. Therefore, the impact of churning on quality measurement is magnified in D-SNPs. Yet, NCQA continues to rank D-SNPs that are serving a dual eligible population with other Medicare Advantage Plans that may be serving a much greater mix of higher income and healthier seniors. We are advocating for separate reporting of D-SNPs.

Finally, we are concerned with the different scoring methodology used by NCQA and CMS and the confusion this may cause. We have examples of health plans that received 3 stars or higher when ranked for a measure as part of the CMS Stars program. However, the plan may be ranked much lower for the same measure under the NCQA scoring methodology based on the same HEDIS scores. The difference in scoring is not conducive to consumer understanding and may cause consumer confusion. Therefore, we strongly suggest that some effort be made by NCQA and/or CMS to harmonize the scoring methodology.

As an example, in NCQA's Health Insurance Plan Rankings 2012–2013, Health Plan of San Mateo ranked 357 out of 395 Medicare plans. Yet the Health Plan of San Mateo scores well on the SNP Structure and Process Measures (usually at 100% for each measure) and the health plan's SNP Model of Care received a 3 year approval. In Medicare Star ratings, the health plan had a 3.5 (above average) rating. In terms of specific quality measures, for the 23 of the 44 CAHPS, HEDIS and HOS measures used in the NCQA ranking process and the Medicare Star Rating process, the NCQA ratings are lower for 13 of the measures and higher in only 3. For example, the plan received a 5 from CMS for the HEDIS measure of Glaucoma Screening, but only a 4 from NCQA in the rankings. The CAHPS composite for Rating of Personal Doctor was rated above average by CMS, but received a "1" by NCQA. Most inexplicable, for the HOS measure managing the Risk of Falls, the plan received a "5" rating from CMS and on "1" rating from NCQA. Moreover, while NCQA advocates for transparency in public reporting, the statistical methodology used for developing the standardized rates is proprietary to NCQA and cannot be examined by health plans to validate accuracy.

As stated above, ACAP continues to support quality measurement and the public reporting of data. We thank you for considering these suggestions to improve the scoring methodology and the NCQA ranking process. Please let me know if you have any questions or wish to meet to discuss these issues.

Sincerely,

Margaret Murray
CEO