ACAP
Association for Community Affiliated Plans

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Quality Management and Operations Committee Report

Summer 2015

A. Trusted Authority

Position ACAP as an expert on publicly-sponsored coverage programs.

A.1 – Ensure the needs and views of the SNHPs are addressed in federal policy debates and research on public health care programs and managed care.

(1) Continue to represent ACAP on national panels.

a. Serving on AHRQ-funded panel on Medicaid Readmissions.
b. Provided comments to CMS on proposed payment strategies for prenatal and postpartum care.
c. Continue to serve as liaison to NCQA standards committee to represent unique needs of Safety Net Health Plans. Submitted Comments on HEDIS changes (measures) and guidelines – pushing for longer transition period for changes on measure rotation.
d. ACAP also submitted comments on HPA 2016 Accreditation Standards. It appears NCQA may accept comment on not tracking out of network requests by line of business. However, it appears NCQA will be less reception to other comments (allow plans to define high-volume specialties, recognize limited number of select practitioners in certain geographic areas, requiring one and not three interventions per year concerning network adequacy, and recognizing that the provider directory issues are related to provider failure to notify plan of changes).
e. Participating on PQA workgroup focused on risk adjusting quality measures to address social economic status.
f. Had call with GAO to discuss issues associated with Non-Emergency Medical Transportation.

A.2 – Promote policy innovations supportive of Safety Net Health Plans through at least one research project per year.

(1) Implemented Bundled Payment Collaborative.

a. Nine plans participated in Phase I.
b. Included extensive data analysis of more than 80 episodes of care.
c. Shared overview of activities with CMCS and CMMI.
d. Provided recommendations to participating plans on implementation strategies.
e. Developed and issued toolkit for all ACAP plans.
f. Offered to repeat Phase I analysis for another cohort of plans. However, there was not enough plan interest to move forward. Will continue to consider new Phase II learning network for plans pursuing implementation of bundled payments.

B. Advocate for Lower-Income and Vulnerable Populations

Influence public policy to support continuation and improvement of publicly-sponsored health coverage programs and Safety Net Health Plans.

B.2–Promote policies which improve enrollment, retention, and quality, and continuity of care across publicly-sponsored programs.

(1) Advocating changes to encounter data submission process to facilitate plan submissions.

a. Met with members of Medicaid Encounter Data Workgroup established by staff of Senate Finance and House Energy and Commerce Committees.
b. Provided health plan perspective on encounter data process and issues.
c. Based on recent call, will develop and submit suggestions to improve the process based on plan input.

(2) Developed ICD-10 policy position.

a. Advocated for no further delays in implementation deadline.
b. Further delays result in confusion, inability to appropriately dedicate resources, and higher implementation costs.
c. Board agreed to remain silent on issue of contingency (running both ICD-10 and ICD-9 concurrently) since there was not agreement on whether this approach should be supported.

(3) Developed Telemedicine policy position.

a. Regulatory environment should promote use of telemedicine.
b. Telemedicine should be counted toward network adequacy requirements.

(4) Developed Prescription Drug Abuse policy positions. Included in SUD Toolkit that was released in mid-April 2015.

a. Lock-in should follow member in timely fashion.
b. Allow lock-in in Medicare Advantage and Part D plans.
c. Allow plan access to prescription drug monitoring databases.
d. Address issue of cash prescribing of Suboxone.
e. Change privacy rules to promote better integration and coordination.
f. Need collaborative process to develop new measures to address issue.

(5) Mental Health Parity.

a. CMS issued proposed Medicaid Mental Health Parity rule. Held two calls with plans to discuss the rule. Submitted comments on June 9.
b. Major issues include (1) lack of level playing field between managed care and FFS and potential unintended consequences; (2) inadequate addressing of uniqueness of Medicaid coverage and services and competing priorities, (3) need to enforce transparent actuarial soundness approach to related rate changes; (4) Parity analysis will be extremely difficult, especially in carve-out situations as it relates to Non-Quantitative Treatment Limits (NQTL) – will require extensive TA for states *and plans*; (5)

the need to clearly define LTC exception; and (6) 18-month implementation needs to be extended. ACAP did not take a position on the use of carve-outs, but supported state flexibility to address local conditions.

B.3–Promote adequate and sustainable payment policies for health programs focusing on lower income and vulnerable populations by positively influencing policy, legislative and regulatory bodies concerning managed care and SNHPs.

(1) Network Adequacy.

a. Submitted comments to NAIC on draft Model Act on Network Adequacy.
b. Developing positions with plan input to address proposed NAIC changes and anticipated changes in Medicaid Managed Care regulations. Continue to monitor NAIC Model Act calls.
c. Submitted a separate letter to NAIC opposing a proposed drafting note that would have addressed the application of the Model Act to Medicaid Managed Care. The drafting note proposal was subsequently withdrawn.
d. CMS proposed managed care regulations on this and other topics currently under review. A call with plans on network adequacy will occur on June 24.

C. Center of Excellence and Accountability

Strengthen ACAP members strategically and operationally to improve their quality, efficiency, competitiveness and sustainability and demonstrate this to our target audiences.

C.1 –Support and enhance ACAP plans' ability to achieve higher-than-average HEDIS and CAHPS scores.

(1) Ongoing plan networking and education on issues related to quality.

a. ACAP prepared annual HEDIS and CAHPS comparison reports and distributed at the Fall 2014 Quality meeting. ACAP plans were significantly better on 48 HEDIS measures, better on 41 measures, worse on 26 measures and significantly worse on 1 measure. Concerning the CAHPS domains, the 15 reported ACAP plans were significantly better on the overall rating of the health plan and health information and customer service, significantly worse on rating of specialist care, and at the national mean for overall health care, getting need care and getting needed care quickly, and rating of personal doctor and rating of how doctor communicated.
b. ACAP is currently accepting orders for NCQA Quality Compass 2015 and encourages plans to submit CAHPS data to the National CAHPS Benchmarking Database and authorize use for 2015 sponsor report.
c. ACAP is working with member health plans to investigate the impact of serving the expansion population on HEDIS scores. Initial data suggest that an issue may exist. Have scheduled call to discuss additional data analysis. We have raised this as a potential issue with NCQA.
d. Roundtables held on a variety of topics (caring for individuals with sickle cell disease, working to provide integrated care to the homeless, Medicaid readmissions, transitions in care from childhood to adulthood, and autism services.)
e. Networking calls held on ICD-10 implementation and PCP rate increase.

f. Call series conducted in conjunction with PQA on the use of medication synchronization to improve adherence.
g. Call series implemented on risk adjustment issues. Will focus upcoming call on how Medicaid can utilize provider capitation payment methodologies to more accurately capture risk scores.
h. New fact sheet released on innovations in care management.
i. Developed new resources for the plans comparing requirements across lines of business on cross-cutting issues (network adequacy, risk adjustment and MLR).
j. The annual quality meeting was held in November 2014. It included sessions focused on interventions to improve quality scores. The 2015 meeting will be held in Austin in October. A quality survey is planned for deployment in advance of the meeting.

(2) Reducing Prescription Drug Abuse Collaborative.

a. Thirteen plans submitted their final action plan reports.
b. Continued with Collaborative networking and educational calls.
c. Thirty-four plan staff, including staff from ten participating Collaborative plans, attended an April meeting in Houston. It featured networking sessions for Collaborative plans and educational sessions for all ACAP plans.
d. The toolkit was completed and released to wide distribution. It included descriptions of health plan projects, tips for plans starting an action plan, and policy issues and recommendations.
e. ACAP presented on Collaborative efforts at 2014 NAMD and Medicaid Managed Care conferences and provided input into CMCS efforts to develop Medicaid Innovation Accelerator Program on prescription drug abuse. Will reach out to Behavioral Health Council on joint webinar.
f. Currently seeking no-cost grant extension. Have received informal approval, but awaiting formal response. Will continue to support current plans, seek new cohort to focus on integration of physical and behavioral health including development of paper on changes to privacy rules to promote better integration, and will explore national meeting focused on breaking down silos in combatting prescription drug abuse.

(3) CIO Support.

a. Twenty-eight plan staff attended the CIO Meeting held in Spring 2015 in Portland, Ore.
b. The meeting focused on issues including cybersecurity, patient engagement, interoperability, strategic opportunities and challenges, ICD-10, NCQA MEM standards, telemedicine and building the right IT teams. Evaluations for the meeting were positive.
c. Working with subcommittee to develop and field 2015 CIO Survey to provide benchmarking data.

(4) Discussions on Potential New Projects.

a. In discussions with Robert Wood Johnson Foundation on potential joint project with MHPA on how plans are addressing childhood obesity.
b. In discussions with Conrad Hilton Foundation on potential joint project with CHCS on SBIRT.
c. Had call with Kresge Foundation on how plans are addressing social determinants.

C.2 – Leverage combined resources of ACAP plans to provide better pricing and improved customer services.

(1) NCQA Quality Compass. In 2014, ACAP was able to provide a 50% discount to ACAP plans for the purchase of NCQA Quality Compass. In 2015, ACAP plans will continue to access a 30% discount. The ordering process is currently under way.

C.3 – Create a training institute to provide education on compliance and regulatory matters.

(1) Establish training academy.

a. First training academy session has been developed with Gorman Health Group.
b. Focus was on Medicare Compliance with agenda input from ACAP and ACAP member plans.
c. Session held on April 9th and 10th at National Harbor following Gorman Health Group Forum.
d. Twenty attendees were able to access Gorman Health Group Forum on free or reduced-fee basis.
e. Evaluations were all favorable. Planning a second session in spring 2016 on Medicaid compliance.
f. Also evaluating other potential sessions including HIPAA Privacy Boot camp with Clearwater Compliance and Leadership Academy for health plan staff.

Other Items of Note

ACAP *Making a Difference* Award. Three nominations were received for the *Making a Difference* Award. The winner, Barry Rock, an HR profession from BMC HealthNet was announced at the Board meeting. The award is to be presented on-site at the employee's health plan at a future date of health plan's choosing.