URAC Comments on Section 6B Accreditation Standards and Reporting for Qualified Health Plans

URAC is pleased to submit its comments on Section 6B of the California Health Benefit Exchange Discussion Draft, concerning "Accreditation Standards and Reporting for Qualified Health Plans."

URAC also welcomes the California Health Benefit Exchange's decision to permit its QHP issuers to obtain accreditation from any accrediting entity recognized by the Department of Health and Human Services (HHS), as mandated under Section 1311(c)(1)(D)(i) of the Affordable Care Act (ACA) and its implementing regulations (under 45 CFR Part 156.275). This conformance with the ACA is also specified under Section 2 of California's own Exchange law, AB 1655.

In a final rule issued by HHS on July 20, 2012, URAC and NCQA were both named by HHS as conditionally eligible accrediting entities for QHP issuers on Exchanges in all 50 states and the District of Columbia. A final HHS announcement formally recognizing URAC and NCQA is expected by the Fall of 2012.

HHS has reviewed both URAC's and NCQA's health plan accreditation programs, and found both to be viable options for accreditation: Each has been designed to meet all ACA requirements for Exchanges, and include robust standards and quality measures.

The letter and intent of the ACA and final Exchange rule are clear: States must support a choice of HHS recognized accrediting entities for their QHP issuers, without giving preference to one over the other. Doing so would not only be non-compliant from a legal perspective, it would also result in rejection of the state's Exchange Blueprint, per guidance provided by CMS's Center for Consumer Information and Insurance Oversight (CCIIO) staff.

As such, we feel it is important for California to recognize both URAC and NCQA on completely equal footing, without creating any incentives or policies favoring the selection of one QHP issuer over the other.

By adopting Congress's and HHS's vision of an unbiased choice of accrediting entities from which QHP issuers may choose, and keeping health insurance affordable, the prime "winner" will be millions of California consumers. Healthy competition of accreditors can help keep accreditation fees low and quality high, permitting more issuers and QHPs to participate, as well as expanding consumer access and choice of plans.

<u>The Future of Quality Measurement and Ratings of Plans Under the ACA</u>

In terms of quality measures and ratings of health plans, Congress and HHS have made it unequivocally clear that they are seeking fresh, innovative approaches in these key areas. In fact, the ACA charges HHS with issuing a uniform national set of quality measures for health plans, as well as a methodology for rating plans, and template for displaying plan ratings on Exchange websites.

Until 2016, when QHP issuers must begin reporting quality measures for the purpose of rating and displaying plans' performance, HHS will rely on URAC's and NCQA's current quality measurement and plan rating approaches to help guide final HHS rulemaking in these two critical areas.

The National Quality Strategy: Building a National Consensus Approach to Measuring Quality

Section 3011 of the ACA mandates the development of a National Quality Strategy, calling for a harmonized "national approach to measuring quality…building a national consensus on how to measure quality so that stakeholders can align their efforts for maximum results." (Source: *2012 HHS Annual Report to Congress, National Strategy for Quality Improvement in Health Care, p.2).*

While HEDIS and CAHPS have been useful and well known, <u>they do not necessarily represent the wave of the future in terms of quality, measurement, and plan ratings.</u> In fact, were a state to use current NCQA plan ratings on its Exchange website, not only would this be non-compliant with current Federal statute and regulations, ultimately, it would cause great confusion for consumers when the state is required to replace its NCQA-based ratings with the methodology and template to be issued by HHS.

NCQA has already announced that it will require that its clinical quality and patient experience measures, as well as plan rating methodology, conform to forthcoming HHS requirements, stating: <u>"Overall, NCQA plans to align the clinical quality and patient experience measures scored in accreditation with any federal requirements."</u> (Source: NCQA June 29, 2012 comment letter on proposed Exchange rule). In the comment letter, <u>NCQA further cites several major technical reasons why it will not score Exchange plans on HEDIS or CAHPS results until 2016 at the earliest</u> (consistent with HHS's timeline for Federally-facilitated Exchanges). URAC agrees with the key reasons for delaying reporting until 2016, which include:

- The first valid, robust clinical Exchange quality data will not be available until June 2015 because plans need at least one complete year to accurately measure their quality performance.

- Some measures require more than one year to fairly measure whether a plan has met guidelines for appropriate care.

- Some Exchange plans may have limited enrollment that is too small in the first few years for quality measures to be statistically valid.

These are all valid reasons for delaying formal reporting to Exchanges until 2016, by which time HHS will have issued its final guidance on clinical quality and patient experience measures, as well as plan rating methodology and Exchange website template for displaying plan ratings. Thus, by 2016, all Exchanges, accrediting entities, and QHP issuers will be in synch, utilizing the same measures and ratings mandated by HHS.

Even though quality measures currently in use by URAC and NCQA will not be used to establish plan performance ratings on Exchanges in the near future, Congress and HHS are looking to both accreditors to see what works best, to help guide future rulemaking in these critical public reporting areas.

The end goal for HHS is to create a single, uniform system for measuring health plan quality and comparative performance that means exactly the same thing across ALL Exchanges. Using publicly available, non-proprietary measures that are built upon national consensus. And providing the layman with information that is clear, transparent, and simple to understand, and which is consistently employed by every health plan and accrediting entity participating on Exchanges in all 50 states and DC.

Benefits of Having a Choice of Accrediting Entities

Having a choice of accrediting entities for QHP issuers has a wide range of benefits for consumers, issuers, and the overall success of the California Health Benefit Exchange. These include:

1. Accrediting entities compete on quality and price, and are driven to continually improve the content of their accreditation programs.
2. QHP issuers can choose the accrediting entity that best meets their needs, in terms of cost, resources, and time required to achieve full accreditation. **(Note:** Historically, URAC's lower accreditation pricing and educational approach has been well suited for small and medium-sized health plan issuers, as well as those which have never previously undergone accreditation. Allowing URAC accreditation could help address one of the "cons" of only using NCQA accreditation listed in the discussion draft found on p. 191: CON: "New entrants and many regional health plans would be challenged to meet participating requirements for the Exchange.)"
3. Keeping accreditation costs down allows a broader range and number of health plans to participate on an Exchange, increasing consumer choice and access, and helping drive down QHP premiums through healthy competition.

URAC Conclusion

While two accrediting entities, URAC and NCQA, will likely be recognized in Phase 1 of Exchange implementation, HHS is encouraging an even larger number of accrediting entities to participate in Phase 2. This further signals HHS's pro-consumer approach to keeping accreditation costs down and premiums affordable. Consistent with the National Quality Strategy, HHS will define a set of uniform national quality measures and plan rating methodology that will be consistently applied across the nation. So, when a person moves from one state to another, an Exchange's display of health plans' quality and ratings will mean exactly the same thing wherever he/she goes.

Given the fact that HHS will ultimately define a uniform national set of health plan quality measures and comparative rating and display methodologies, we do not believe it would be in California's best interest to lock itself into a single approach to quality measurement and rating plans. Giving a preference or advantage to one HHS recognized accrediting entity is proscribed by the ACA and final Exchange rule, and would delay approval the state's Exchange Blueprint, according to CCIIO staff. We thus heartily recommend that California recognize both URAC or NCQA on equal footing, and not create any incentives or policies that would favor the use of one over the other for accreditation.

Giving QHP issuers a choice of accrediting entities is not only the best way to help ensure there is enough capacity to accomplish all accreditations within timelines established by the state, but also provides issuers the opportunity to select the accreditation program which best meets its needs, budget, and staff resources. Consumers are the ultimate winners, having more plans to choose from, lower and more competitive premiums, and better quality care resulting from rigorous accreditation requirements, and ongoing issuer monitoring by accrediting entities and their Exchanges.