Overview of NCQA Accreditation

California Department of Health Care Services
Medi-Cal Healthier California for All Accreditation Workgroup
January 21, 2020

Agenda

WHO USES & WHY: STATES & ACCREDITATION

NCQA HEALTH PLAN ACCREDITATION REQUIREMENTS & SCORING

MAKING THE MOST OF ACCREDITATION: MED MODULE AND LTSS DISTINCTION

DELEGATION: ENSURING ACCOUNTABILITY

DELEGATE OPTIONS FOR ACCREDITATION

APPENDIX: DETAILED TIMELINE OF NCQA SURVEY PROCESS

What We Do and Why

OUR MISSION

To improve the quality of health care

OUR METHOD

Measurement

We can't improve what we don't measure

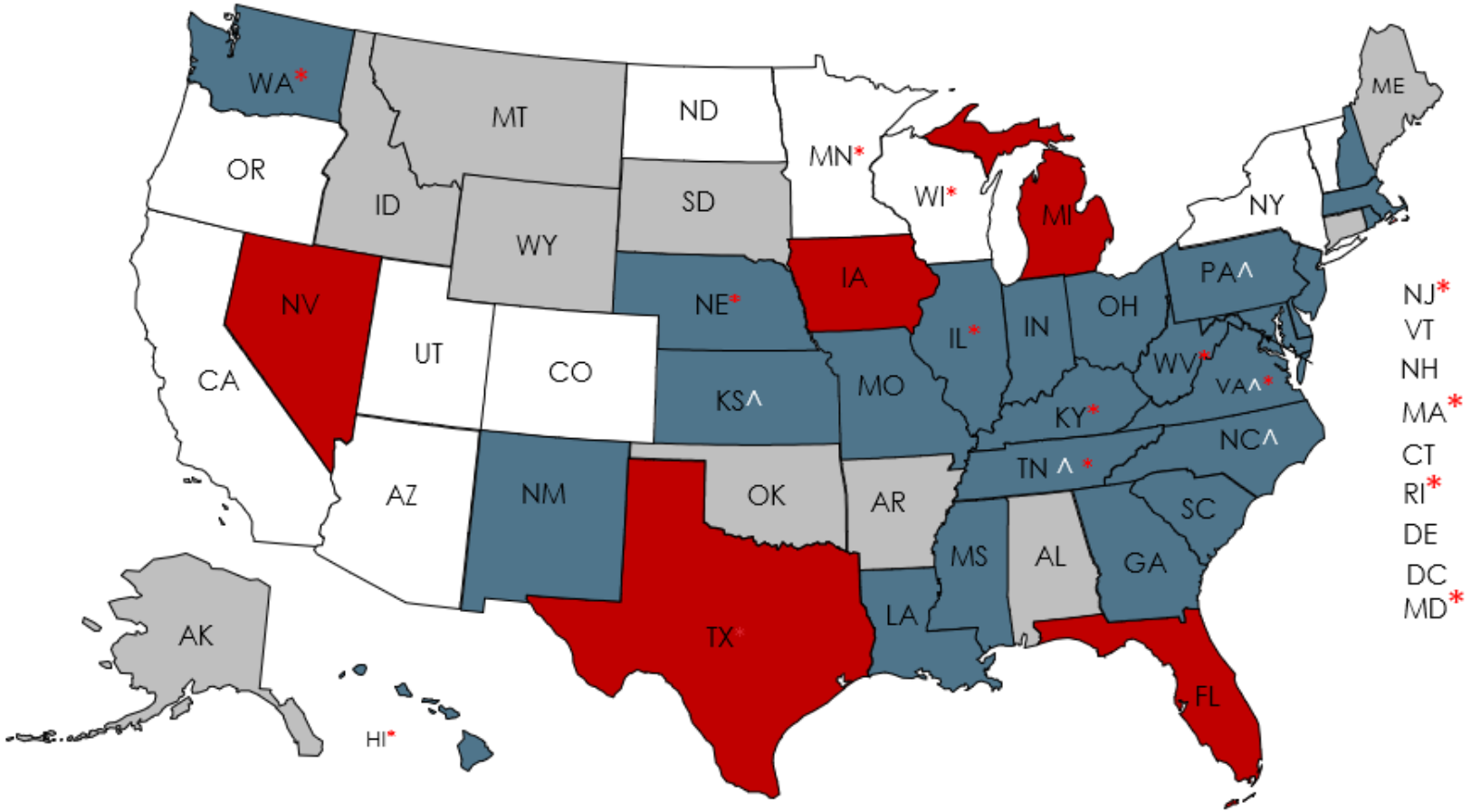
Transparency

We show how we measure so measurement will be accepted

Accountability

Once we measure, we can expect and track progress

Medicaid Managed Care - NCQA Health Plan Accreditation *(January 2020)*



Required to Obtain NCQA Accreditation (26)

Requires Accreditation, NCQA Accepted (5)

* Deems Accreditation

Accreditation Not Required (11)

No Managed Care (10)

^ Requires or Recognizes NCQA LTSS Distinction (5)

California's NCQA Accredited Medi-Cal Plans

17 of the 26 Medi-Cal Managed Care Plans (MCPs)

1. Aetna Better Health of CA (In Process)
2. Alameda Alliance for Health
3. Anthem Blue Cross of California Partnership Plan
4. Blue Shield of California Promise Health Plan
5. California Health & Wellness
6. CalOptima
7. Community Health Group
8. Contra Costa Health Plan
9. Health Plan of San Joaquin
10. Health Plan of San Mateo (Provisional)
11. HealthNet of California
12. Inland Empire Health Plan
13. L.A. Care Health Plan
14. Molina Healthcare of California Partner Plan Inc.
15. Partnership HealthPlan of California (Interim)
16. San Francisco Health Plan
17. UnitedHealthcare Community Plan of CA (Interim)

8 Plans Not Yet NCQA Medicaid Accredited:

CalViva Health, CenCal Health, Central Coast Alliance for Health, Gold Cost Health Plan, Kern Family Health Care, Kaiser (North & South), & Santa Clara Family Health Plan

Plan List: Medi-Cal Managed Care Health Plan Directory

Health Plan Accreditation: Scope of Review

6 Categories and 2 Optional Areas of Evaluation

Standards help plans in:

Quality Management and Improvement. Helps plans measure performance and implement effective improvements to drive better outcomes of care and services for their members.

Population Health Management. Helps ensure plans have a cohesive plan of action for addressing member needs across the continuum of care.

Network Management. Directs plans to provide and maintain appropriate access to care—availability of services, practitioners and information to ensure beneficiaries can get the care they need.

Utilization Management. Helps plans develop processes and procedures to provide timely communications that keep members and practitioners informed about coverage decisions.

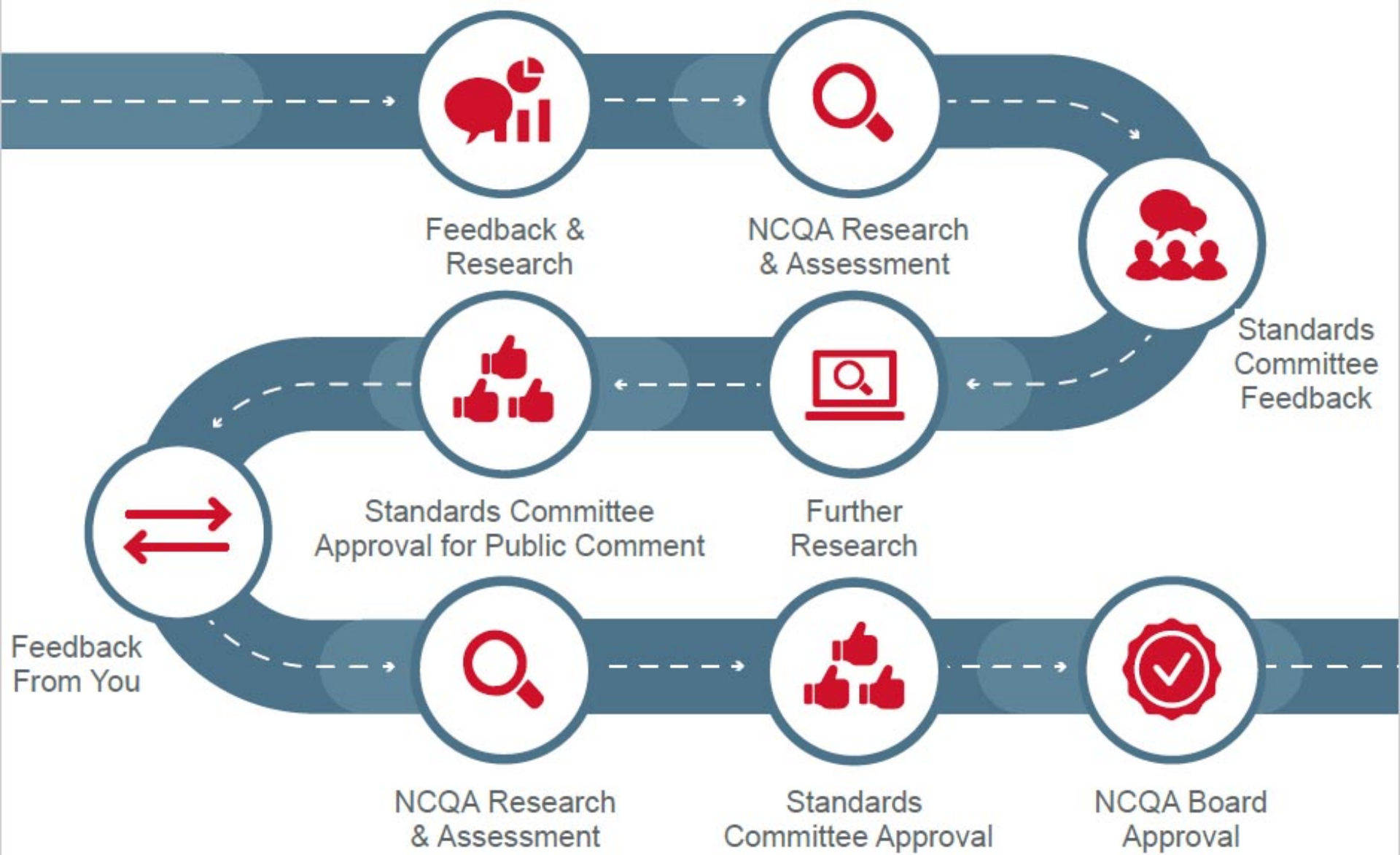
Credentialing and Recredentialing. Helps protect beneficiaries by requiring plans to implement and maintain processes for accurate and timely verification of physician credentials.

Member Experience. Guides plans to implement effective policies and procedures and distribute communications that safeguard members' rights and responsibilities.

Additional areas of review available to plans and states:

- *Medicaid Module (MED) maximizes deeming*
- *Long-term Services and Supports (LTSS) for MLTSS states*

How Accreditation Updates Get Made



Health Plan Accreditation

Achieving Accreditation: Starting in 2020

Must-Pass Elements

Ensuring the plan meets critical elements before being accredited

Must score "Met" on all to achieve "Accredited" without corrective action and/or Resurvey

*Missing 3 in UM **timeliness** may result in denial*

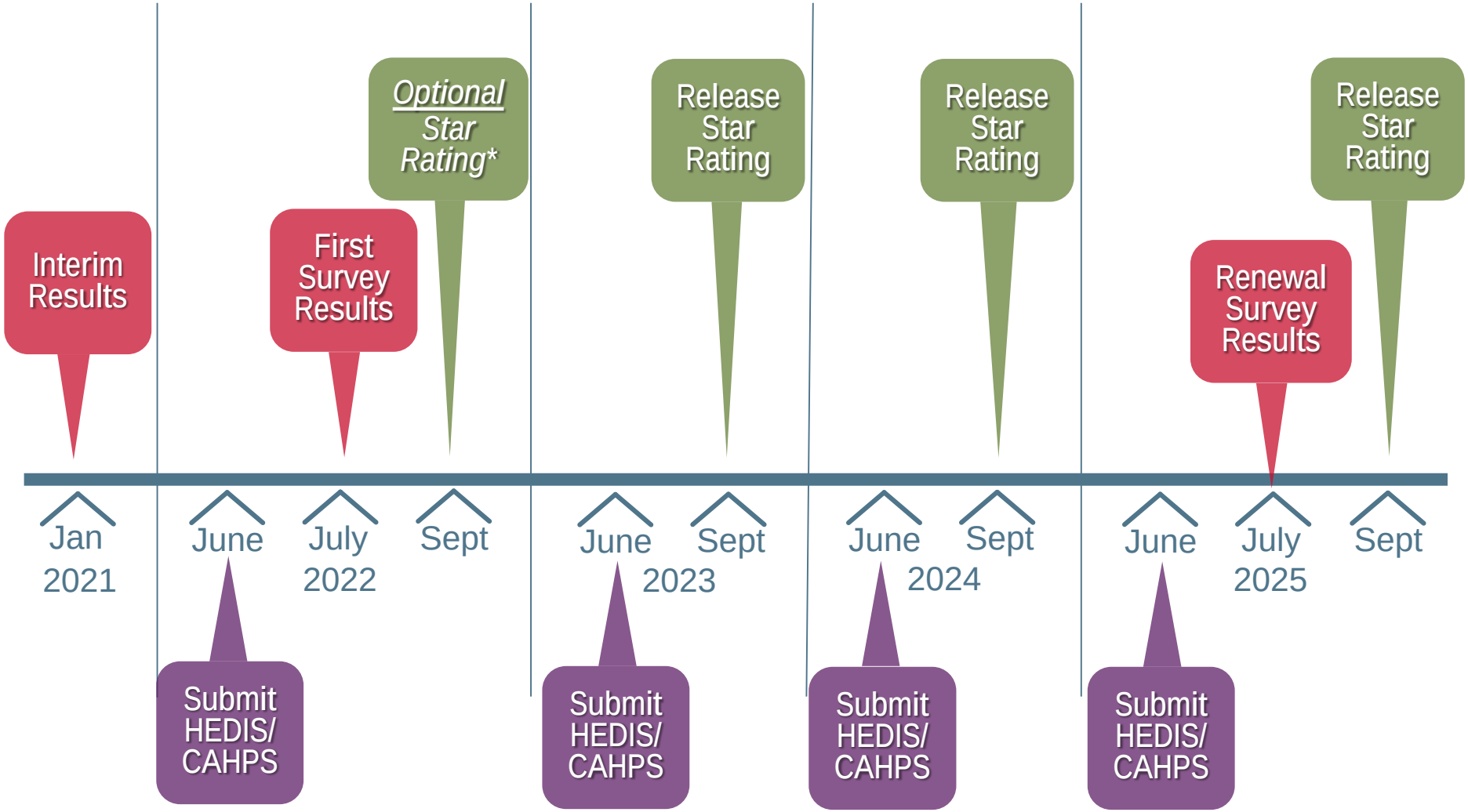
UM and CR file review

UM and CR system controls

Element list in *Policies and Procedures – Section 2*, subsection *How Standards Are Scored,* explanation for "Must Pass Elements and Corrective Action Plan"

Starting with Interim Accreditation

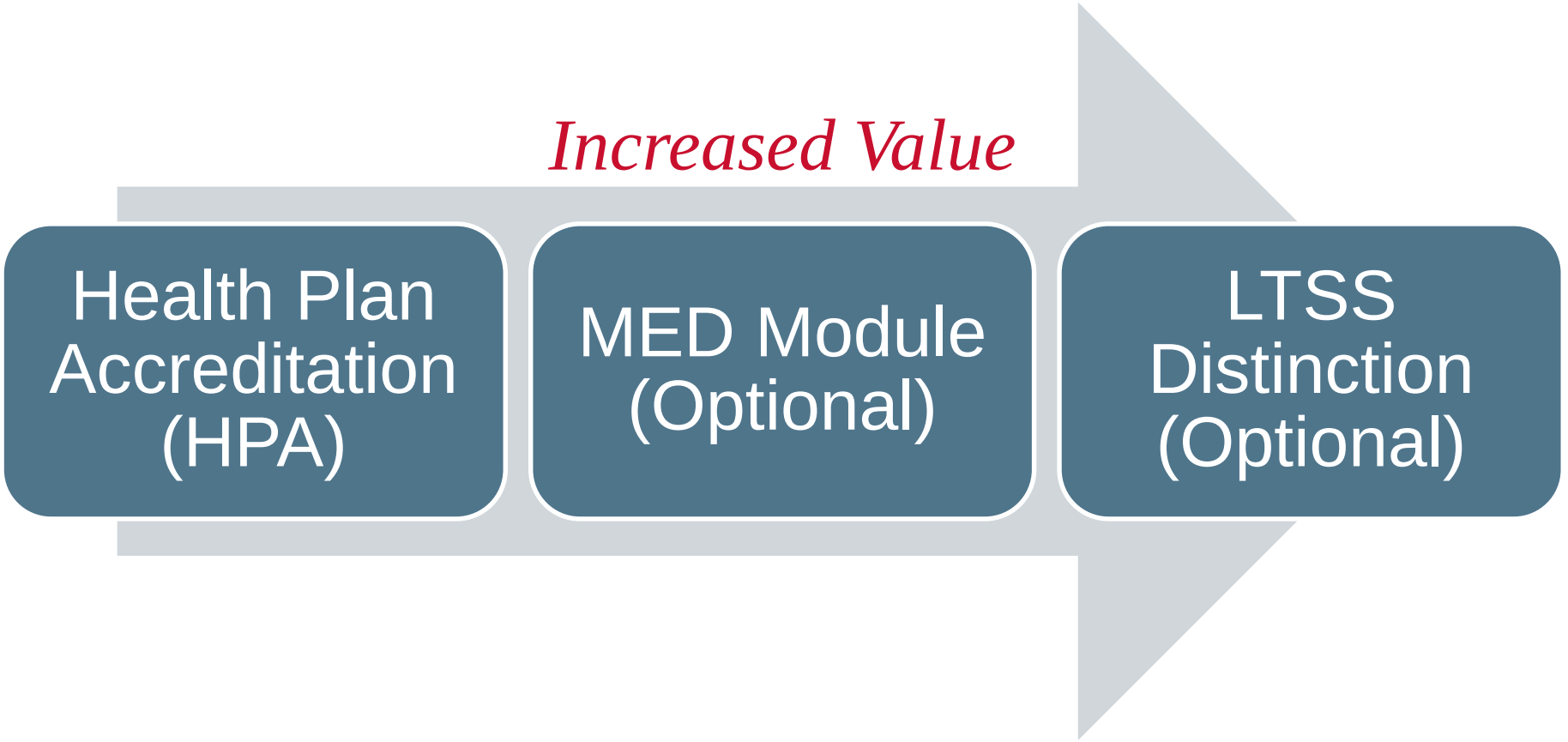
Sample Timeline



Star Rating Optional First Year

Medicaid Accreditation Components

NCQA Health Plan Accreditation: Accountability Model



Building on HPA's foundation, the MED module and LTSS Distinction standards provide the full continuum of potential value accreditation can offer

The Medicaid Module (MED)

Federal Medicaid standards developed to maximize deeming

MED 1: Medicaid Benefits and Services

MED 2: Practice Guidelines

MED 3: Practitioner Office Site Quality

MED 4: Privacy and Confidentiality

MED 5: Care Coordination

MED 6: Initial Screening and Assessment of Members

MED 7: Quality Assessment and Performance Improvement

MED 8: Informing Members of Services

MED 9: UM Decisions About Payment and Services

MED 10: Grievances and Appeals

MED 11: Continued Coverage

MED 12: Information Services for Members

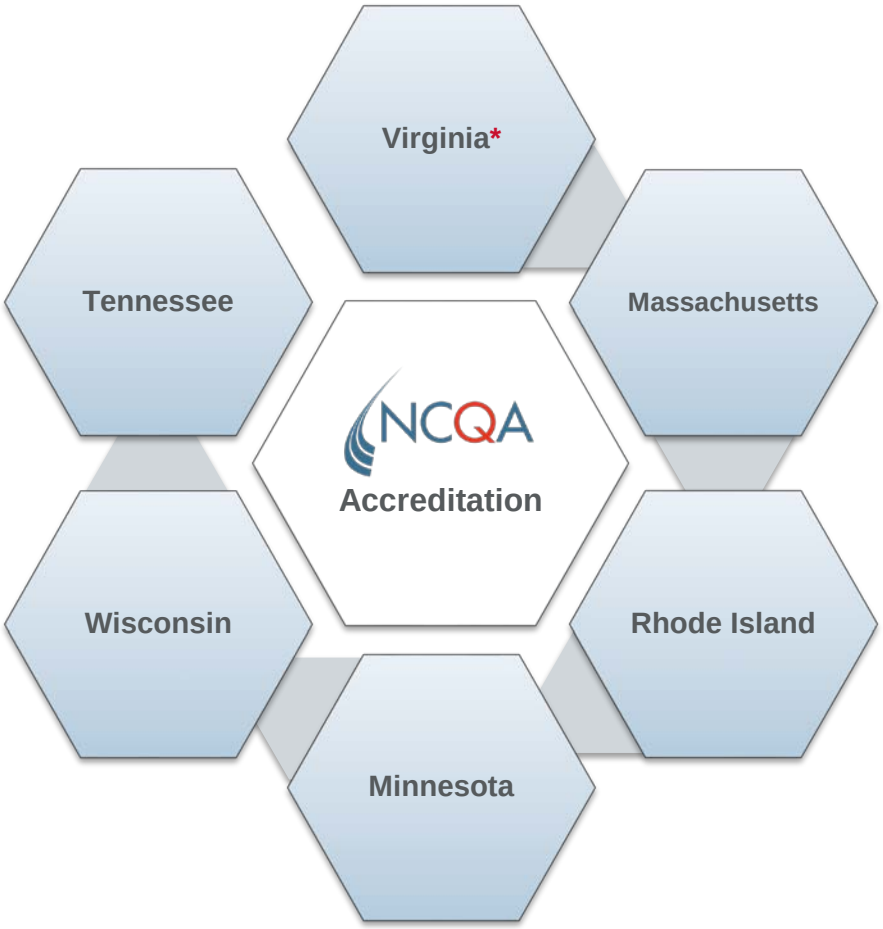
MED 13: Member Communications

MED 14: Practitioner and Provider Directories

MED 15: Delegation of Medicaid

All elements in the Medicaid Module are scored with a performance score of Met or Not Met. Organizations can submit to a voluntary CAP for Not Met elements

Non-Duplication in State Quality Strategies



12 states reference non-duplication

- All require NCQA accreditation
- 1 includes LTSS Distinction

- Hawaii
- Illinois
- Kansas
- Kentucky
- Louisiana
- Maryland
- Nebraska
- New Hampshire
- New Mexico
- North Carolina*
- Washington
- West Virginia

6 states include detailed use of Accreditation

- 4 require NCQA Accreditation
- 1 includes LTSS Distinction

** Requires LTSS Distinction*

LTSS Distinction: Overview & Scoring

LTSS Standards for HPA and MBHO Accredited Organizations

LTSS 1: Core Features

Develop key components foundational to a health plan or MBHO responsible for LTSS

LTSS 2: Measure and Improve Performance

Measure member experience, program effectiveness and participation rates and take action to improve performance.

LTSS 3: Care Transitions

Establish a process for safe transitions and analyze the effectiveness of the process.

LTSS 4: Delegation

Monitor the functions performed by other organizations for the health plan.

Scoring

Status Level	Standards Score
Distinction	70-100 points
Denied	Below 70 points

What is “Delegation”?

- An organization gives **authority** to another organization (delegate) to perform an activity that the client would otherwise perform to meet NCQA’s requirements.

- The organization retains **responsibility** and **accountability** for the delegated NCQA requirement, whether the organization performs the activities or whether they are performed by a delegate or subdelegate.

Importance of Delegation Oversight

Holding delegated organizations accountable

Organization is assessed under NCQA standards.

Organization needs to know that its **delegate** adheres to NCQA and its own standards.

Organization is ultimately responsible for the activity and execution.

UM, CR, PN, CM Accreditations

Tools for delegate accountability

Utilization Management

- Use evidence-based criteria when making UM decisions.
- Use of relevant clinical information to make UM decisions.
- Use of qualified health professionals to assess requests & make UM decisions.

Credentialing

- Verification through primary source, recognized source, or a contracted agent of the primary source.
- Use of a Credentialing Committee that reviews credentials and makes recommendations.
- Monitors practitioner sanctions, complaints and quality issues between credentialing cycles.

Provider Network

- Consistent monitoring of practitioner availability and accessibility of services.
- Efficient collection & analysis of member-experience data.
- Appropriate credentialing of practitioners and providers.

Case Management

- Focus on effective handling of care transitions and adaptations to suit programs that are standalone or based in the community, delivery system or health plan.
- Systematically identifies patients for case management and performs initial assessments.
- Capabilities in place to support case management activities, and monitors individualized care plans

CM-LTSS, PHP, MBHO Accreditations

Tools for delegate accountability

Case Management for Long-term Services and Supports

- Designed for community-based organizations (CBOs) that coordinate LTSS only for populations with complex care needs. CM-LTSS establishes accountability through structure and process for CBOs.
- Services are more person-centered, which means more individuals stay in their homes and communities.
- Improves communication between person and providers, and providers and payers
- Supports managed care population health strategy

Population Health Programs

- Eligible population health programs are expected to use a “whole-person” approach that follows a person-centered model to integrate care for both physical and psychosocial needs.
- These programs consider care needs at all stages of life, as well as acute care, chronic care and preventive services.

Managed Behavioral Healthcare Organizations

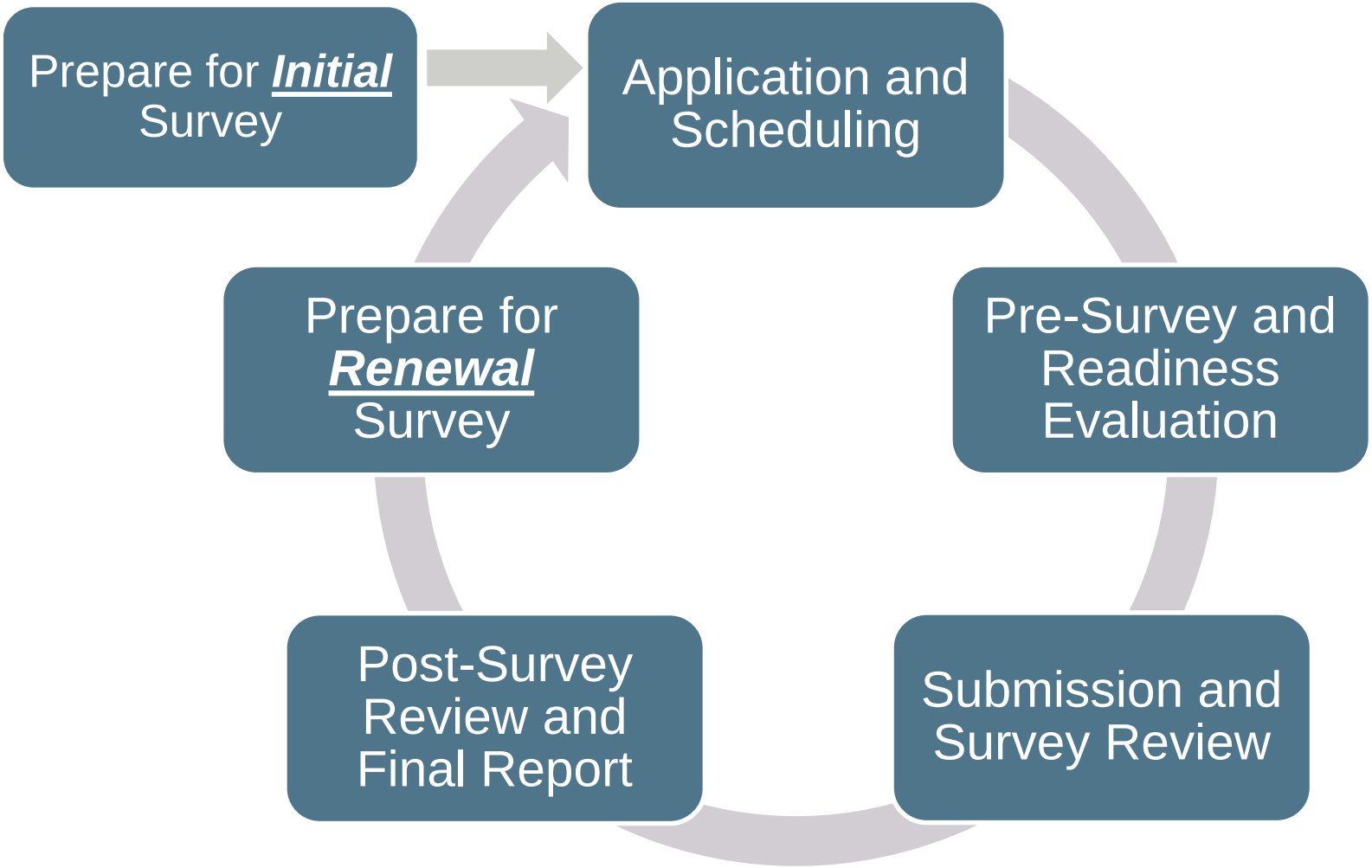
- MBHO Accreditation requires organizations to monitor, evaluate and improve the quality and safety of care provided to members; coordinate medical and behavioral healthcare; meet standards for access and services; and review and verify the credentials of the practitioners in their network.


NCQA
Measuring quality.
Improving health care.

Appendix: Survey Process

NCQA Survey Process

The Survey Cycle



NCQA Survey Process

*Application & Scheduling – **Initial** Surveys*

Approximately **9-12 months** before desired survey start date -

- Consultative Call with NCQA Program Expert
- Purchase Standards
- Perform a Gap Analysis
- Submit Prequalification Form

Approximately **9 months** before desired survey start date -

- Submit Application
- Pay Application Fee
- Sign and Submit Survey Agreement

Approximately **9 months** before desired survey start date -

- Organization is assigned an Application and Scheduling Account Representative (ASAR)
- ASAR Reviews and Assists with Resolving Open Issues with Application
- Survey Dates are Confirmed (Submission and Onsite Dates)
- Survey Agreement Finalized (signed by NCQA)

NCQA Survey Process

*Application & Scheduling – **Renewal** Surveys*

Renewal survey dates are proactively scheduled
- Renewal survey dates noted in final survey letters
- Scheduled to begin 3 months before accreditation status expires

Organization purchases applicable standards for Renewal survey

Approximately **13 months** before renewal survey submission date -
- ASAR sends 'NCQA Application Notice Letter' email

Approximately **9 months** before renewal survey submission date -
- Submit Application
- Pay Application Fee
- Sign and Submit Survey Agreement
- ASAR Reviews and Assists with Resolving Open Issues with Application
- Survey Agreement Finalized (signed by NCQA)

NCQA Survey Process

Pre-Survey and Readiness Evaluation

Once survey dates scheduled and standards purchased -
- Organization prepares for survey

Approximately **6 months** before survey start date -
- Accreditation Survey Coordinator (ASC) assigned

Approximately **2-3 months** before survey start date -
- Introductory Call with ASC (9-12 weeks)
- Surveyor assignments with resumes and Conflict of Interest Forms
- Organization receive final survey invoices (60 days)

Approximately **1 month** before survey start date -
- Pre-submission deliverables due to ASC (6 weeks)
- Pre-Submission selections sent to organization
- Final survey fee due

On **Survey Start Date** -
- Organization submits completed IRT survey tool to begin survey review

NCQA Survey Process

Survey Review Process

Offsite Review -

- Begins with IRT submission
- Surveyors conduct initial reviews and documents outstanding issues
- Organization identifies issues to discuss with surveyors
- Survey Conference Call (3.5 weeks after submission)
- Organization prepares final responses to outstanding issues
- Surveyors finalize offsite
- Organization receives final file selections and prepares for onsite (10 business days prior to onsite)

Onsite Review -

- Takes place **approximately 7 weeks after submission**
- One-Day In-person or Virtual Onsite
- Surveyors conducts file reviews and finalizes all survey assessments
- Closing Conference - Surveyors presents strengths/opportunities and next steps

NCQA Survey Process

Post-Survey and Final Report

Executive Review (ER) stage -

- Extensive, Internal NCQA Review
- Begins morning after completion of Onsite

Preliminary Report/Organization Comment Period -

- Opportunity for organization to comment on any errors/omissions, if any
- Often begins within 10 business days of onsite completion
- Organizations given 10 business days to review report and submit comments, if any

Incorporation of Organization Comments -

- Internal NCQA review and incorporation of comments and NCQA responses into final report

Review Oversight Committee (ROC) Review and Final Report -

- Survey report sent to ROC for final Accreditation determination
- Final Accreditation decision and survey report released to organization
- **Goal – 34 calendars days after completion of Onsite review**

Must-Pass Elements, Status and Corrective Action

The Details

	Corrective Action	Possible Status	Resurvey
Fail ≥3 *UM Timeliness*		• Denied	
Fail ≥3 overall, *<3 UM Timeliness*	• Required	• Provisional • Listed as "Under Corrective Action"	• Required
Fail 1–2 MP Elements	• Required	• Accredited or Provisional • Listed as "Under Corrective Action"	• Possible

Corrective Action Plan (CAP)

- Written CAP due to NCQA within 30 days of final results
- NCQA reviews proposed CAP, provides initial response
- NCQA reviews implementation of the CAP; may include resurvey

The above are *guidelines*.
All actions, statuses determined by the Review Oversight Committee.

Final Results

- **Notified via email that final results are available in IRT**
- **Includes information for each product/product line surveyed**
  - Overall score
  - How scored (i.e., standards only, standards plus CAHPS or standards plus HEDIS/CAHPS
  - Status
  - Valid dates

Final Results: Summary & Detail

- **Standards scores**
  - Total
  - Elements
  - Must-pass results
- **HEDIS scores**
  - Total
  - Total clinical and individual measures
  - Total CAHPS and individual measures