NCQA Briefing: CA DHCS Care Coordination Advisory Committee

August 29, 2018

Agenda

WHO USES & WHY: STATES & ACCREDITATION

MAKING THE MOST OF ACCREDITATION: MED MODULE AND LTSS DISTINCTION

NCQA HEALTH PLAN ACCREDITATION REQUIREMENTS & SCORING

POPULATION HEALTH: ADDRESSING SOCIAL DETERMINANTS, INTEGRATING COMPLEX CASE MANAGEMENT AND MORE

DELEGATION: ENSURING ACCOUNTABILITY

IPA ACCOUNTABILITY: OPTIONS FOR ACCREDITATION

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

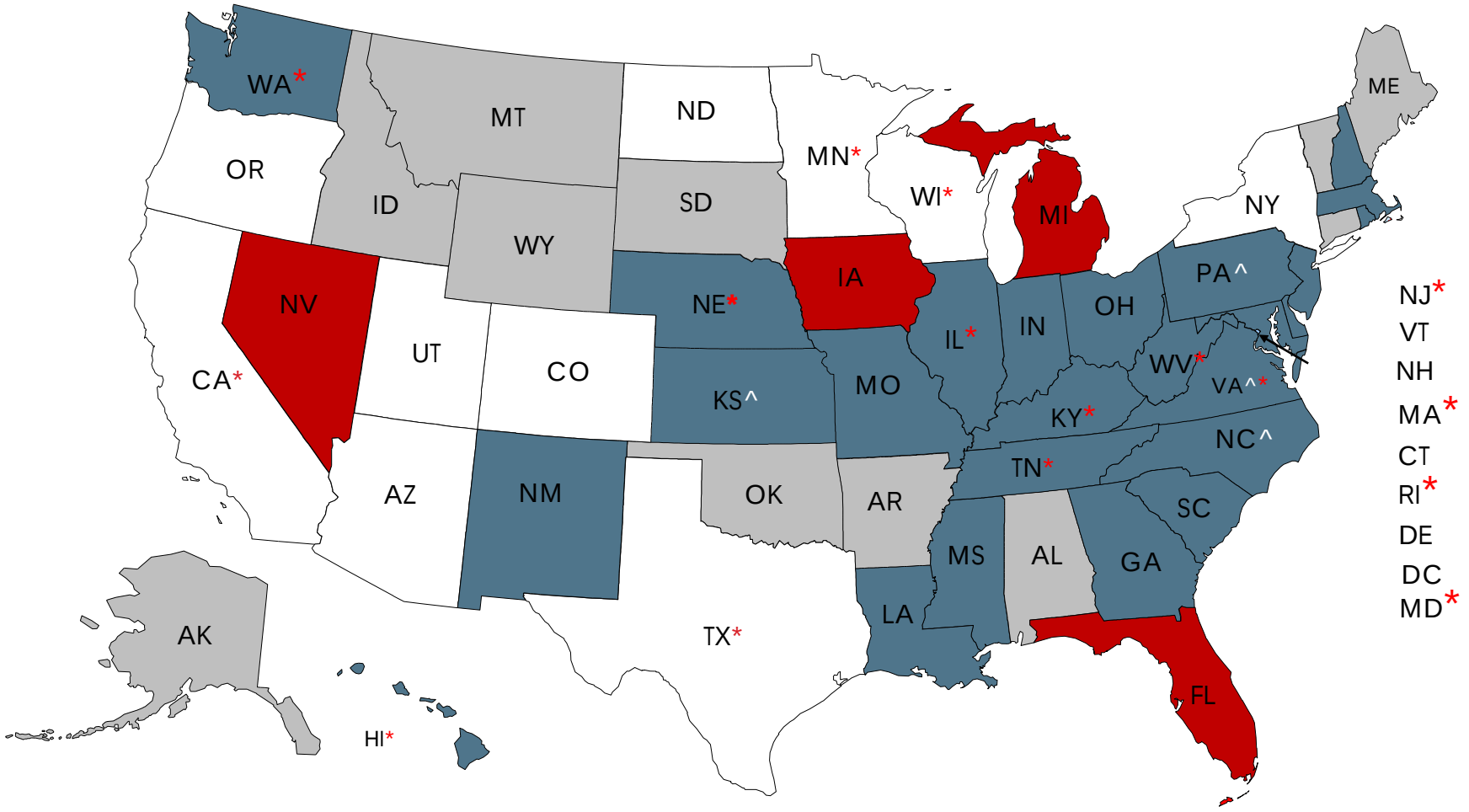
Accountability

Once we measure, we can expect and track progress

States Making the Most of Accreditation

Most Widely Used Program in the Nation

26 Medicaid Managed Care States Require NCQA Accreditation



Value of NCQA Accreditation for States

Why Accreditation?

Regulator: Streamlines Oversight
√ Aligns with federal Medicaid managed care requirements
√ Can be used to meet state specified requirements
√ Aligns quality expectations for plans serving non-Medicaid enrollees
√ Supports program integrity
Purchaser: Ensures Plan Accountability
√ Performance drives Accreditation Status level
√ Allows for apples-to-apples plan comparisons

What is the Non-duplication Provision?

Quality Strategy: Non-duplication provisions

- "Under §438.352, to avoid duplication the State may use information from a Medicare or **private accreditation review** of a Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP), or Prepaid Ambulatory (PAHP) to provide information for the annual External Quality Review (EQR) instead of conducting one or more of the EQR activities"

- States can give plans credit for meeting certain state and federal Medicaid requirements based on how they scored on select standards. This process is commonly known as "deeming."

Value of Implementing Non-Duplication for States

Making the most of the state healthcare resources

Annually reporting of audited HEDIS and CAHPS aligns with performance measure validation

Accreditation review aligns with many structure and process requirements

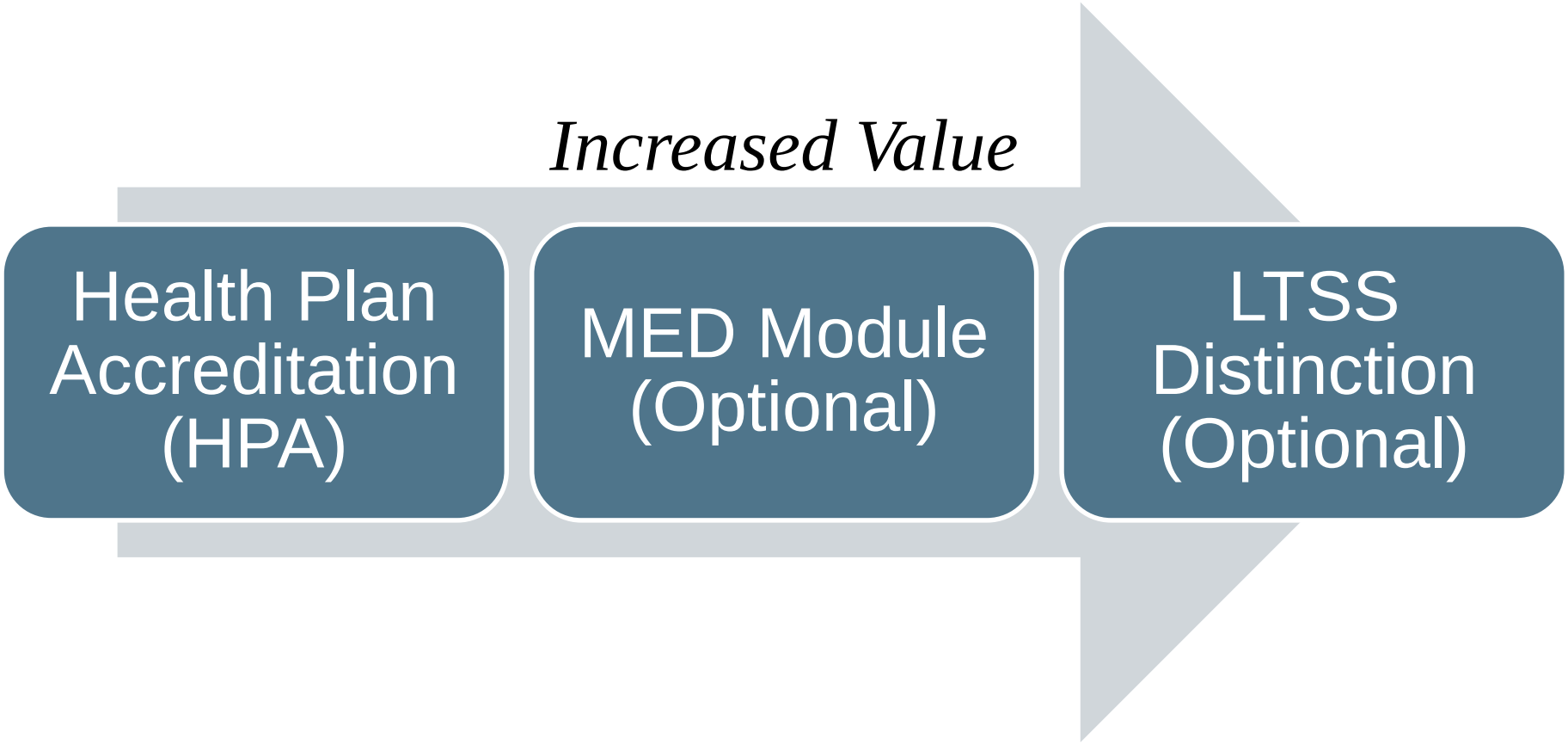
Reduces duplicative review for states and plans = resources saved and improved plan relations

RESULTS:

- ✓ Gives state $ to refocus EQRO resources on other projects
- ✓ State shows it's maximizing value in its managed care quality and oversight

Medicaid Accreditation Components

NCQA Health Plan Accreditation: Accountability Model



Maximizes data from NCQA review for state program integrity and non-duplication

LTSS Distinction Eligibility

Designed for organizations that coordinate both medical care and LTSS.

- Health plans offering comprehensive services that include LTSS benefits
- MBHOs that manage and coordinate LTSS benefits
- CM organizations that coordinate medical care and LTSS

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

More on LTSS 1: Core Features

Program Description	Assessment of Health, Functioning and Communication Needs	Resource Assessments
Comprehensive Assessment Implementation *(file review)*	Person-Centered Assessments	Person-Centered Care Planning Process
Implementing the Care Planning Process *(file review)*	Critical Incident Management System	Qualifications and Assistance for LTSS Providers

NCQA Health Plan Accreditation

Health plan accreditation is

STRUCTURE & PROCESS

50% of score

HEDIS
Performance Measures
(Clinical)

+

CAHPS 4.0H
(Patient Experience)

50% of score

Performance-based accreditation

Accreditation Status

Scoring Ranges

Status	Scoring Range	
	Interim (Standards Only)	**First and Renewal (With HEDIS/CAHPS)**
Excellent	NA	90–100
Commendable	NA	80–89.99…
Accredited	NA	65–79.99… with at least 30 of the possible 50 points on standards
Provisional	NA	55–64.99… with a minimum of at least 30 of the possible 50 points on standards
Interim	35-50	NA
Denied	Below 35	Below 55

2018 Standards: Categories & Points

- 7 structure and process categories; 2 optional
- 50 points allocated across them
- Points vary by evaluation option - not every option has every standard

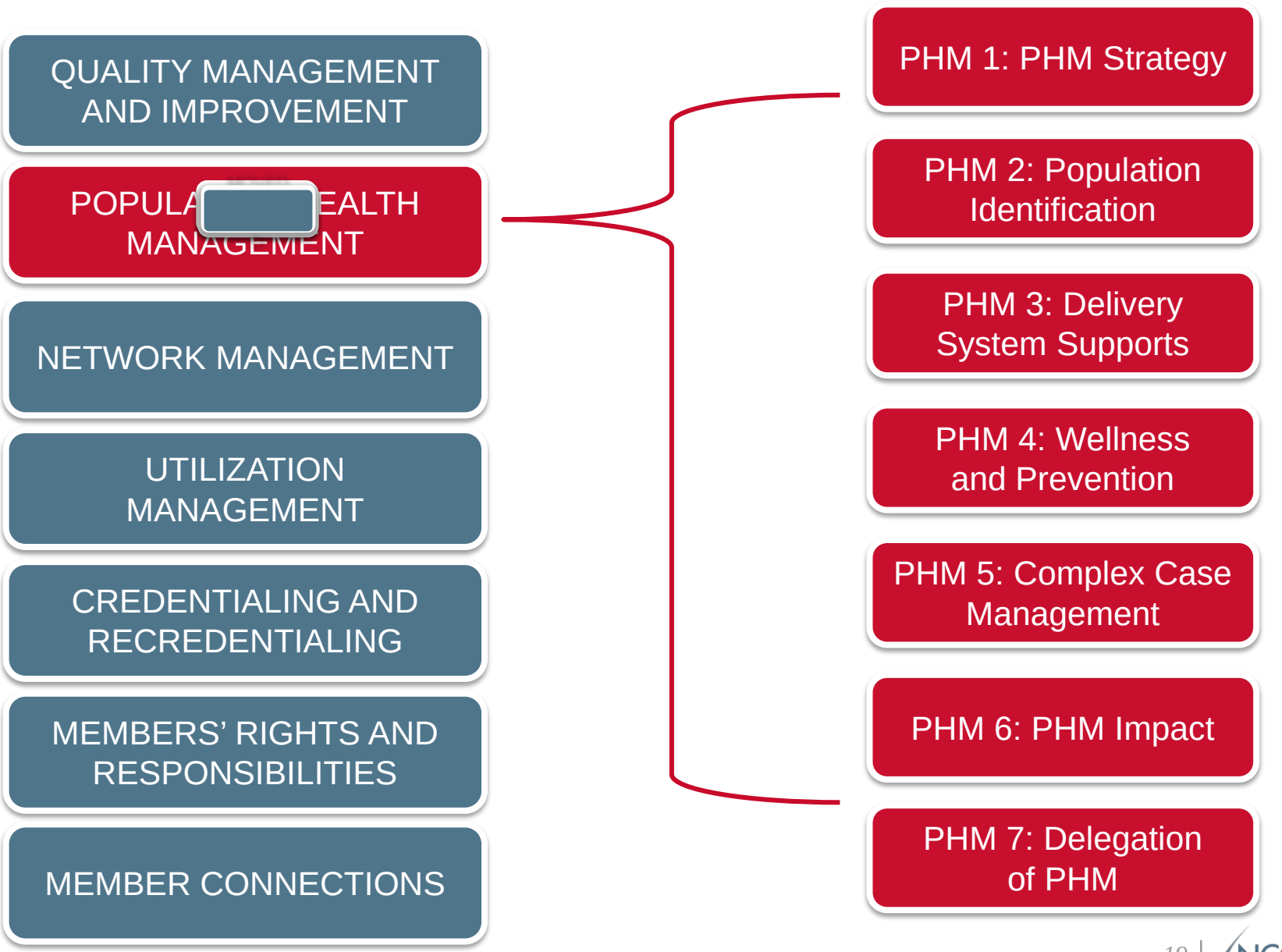
Category	Interim	First	Renewal
Quality Improvement (QI)	12.82	10.00	10.00
Population Health Management (PHM)	7.55	8.00	8.00
Network Management (NET)	1.06	9.00	9.00
Utilization Management (UM)	13.73	10.00	10.00
Credentialing (CR)	5.40	5.00	5.00
Member Rights and Responsibilities (RR)	9.30	5.00	5.00
Member Connections (MEM)	N/A	3.00	3.00
Medicaid Module **(optional)**	All Elements must be "Met" to pass. Any Elements "Not Met" require a correction action plan (CAP).		
LTSS Distinction **(optional)**	Not Eligible	100 (70 to pass)	100 (70 to pass)

Population Health Management and Complex Case Management

The Basics

- **Overview**
  - There are 6 standards in the Population Health Management category
  - There is 1 standard for delegation oversight
  - Intent is that plans have a cohesive plan of action for addressing member needs across the continuum of care

New PHM Category in Health Plan Accreditation



PHM Standards Category in Health Plan Accreditation

PHM 1: PHM Strategy
Requires organizations to have a comprehensive and descriptive strategy for the plan's PHM program.

PHM 2: Population Identification
Integrate data to assess member population and identify needs. Divide population into actionable segments.

PHM 3: Delivery System Supports
Promote data, comparative cost and quality information sharing and value based arrangements with providers.

PHM 4: Wellness and Prevention
Preventing illness and injury and promoting health and productivity.

PHM 5: Complex Case Management*
Help members with complex conditions obtain access to care.

PHM 6: PHM Impact
Evaluate effectiveness of PHM strategy.

** = file review*

PHM 5: Complex Case Management

Element A: Access to Case Management
Multiple avenues for members to be considered for complex case management services.

Element B: Case Management Systems
Use of case management systems that support evidence based guidelines and automated systems.

Element C: Case Management Process
Complex case management policies and procedures that address the assessment and evaluation of member needs.

Element D: Initial Assessment*
Review of the organization's complex case management files.

Element E: Ongoing Management*
Ongoing review and assessment of complex case management plans and goals.

Element F: Experience with Case Management
Evaluate member experience with the complex case management program.

** = file review*

Social determinants of health

PHM 5D, Factor 5

“Social determinants of health” defined:

Economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks that may affect a member’s ability to meet case management goals

Evaluation of community resources

PHM 5C, Factor 10

Established Minimum *Policy* Requirements

- Community Mental Health
- Transportation
- Wellness Programs
- Nutritional Support
- Palliative Care Programs

Complex case management policies and procedures require assessment of the member's *eligibility for* and *availability of* community resources.

Delegation

What is “Delegation”?

- An organization (client) gives **authority** to another organization (delegate) to perform an activity that the client would otherwise perform to meet NCQA’s requirements.
- Client organization retains **responsibility** and **accountability** for the delegated NCQA requirement.

Importance of Delegation Oversight

How else do you know?

Client organization is assessed under NCQA's standards.

Client organization needs to know that its delegate adheres to NCQA and its own standards.

Client organization is ultimately responsible for the activity and execution, not the delegate.

Delegation Evaluation

NCQA evaluates delegation in two ways

Directly evaluating delegate performance for delegated functions.

Evaluating the client organization's oversight

Delegation Oversight Requirements

Documentation required

- Formal delegation agreement
- Predelegation evaluation
- Review of delegate activities*
- Opportunities for improvement

Delegation Oversight

If an organization delegates, oversight standards are found as the last standard of each category...

QI	PHM	NET
UM	CR	RR
MEM	MED (if applicable)	LTSS (if applicable)

Accreditation Options for IPAs

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.

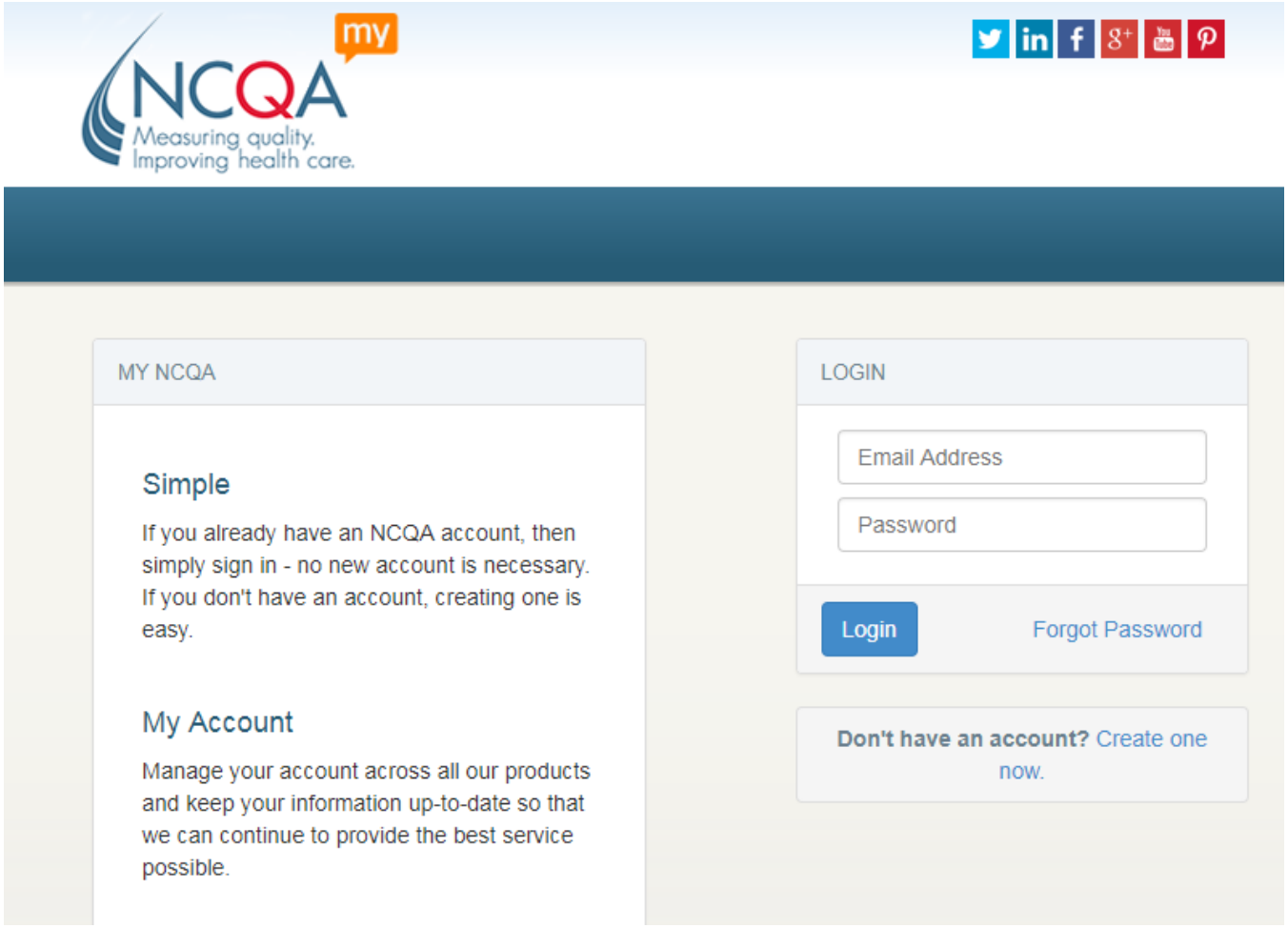
Case Management

- 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

Resources

Policy Clarification System (PCS)

NCQA Health Plan Accreditation Standards Interpretation



https://my.ncqa.org/