Objectives

• Provide an introduction to the NCQA accreditation process
• Describe the HEDIS® and CAHPS ® Quality Measurement processes
• Provide an overview of the NCQA Health Plan standards
• Describe similarities and differences between Health Plan standards and MBHO standards
NCQA ACCREDITATION
Accreditation / Certification / Recognition

Accreditation
1. Health Plan (HPA)
2. Managed Behavioral Health Organization (MBHO)
3. Disease Management (DM)
4. Case Management (CM)
5. Wellness & Health Promotion (WHP)
6. Accountable Care Organizations (ACO)
Accreditation / Certification / Recognition

Certification

1. Credentials Verification Organizations (CVO)
2. Disease Management (DM)
3. Health Information Products (HIP)
4. Multicultural Health Care (MHC)
5. Physician and Hospital Quality (PHQ)
6. PCMH Content Expert Certification (CEC)
7. Utilization Management and Credentialing (UM/CR)
8. Wellness & Health Promotion (WHP)
Health Plan Accreditation Components
100 points

NCQA Standards Compliance (Triennial)
50 Points
HEDIS (Annual)
37 Points
CAHPS (Annual)
13 Points
Health Plan Accreditation Status

Standards + HEDIS + CAHPS = Accreditation Score

- Excellent – 90.00 - 100.00
- Commendable – 80.00 - 89.999
- Accredited – 65.00 – 79.99
- Provisional – 55.00 – 64.99
- Interim (Used for Exchanges)
- Denied – 0 – 54.99
MBHO Accreditation
100 Points Possible

• “Full” Accreditation – 84 - 100 points
• Scored only on Standards compliance
• Must achieve > 20% on all “must pass” elements and “critical factors”
• Status awarded following survey every three years
Survey Process

Application

ISS Submission (Survey Begins)

Onsite Survey

Results
File Reviews

• Conducted onsite
• Includes complex case management, UM medical necessity denials, UM member appeals, credentialing/recredentialing
• Delegate files are subject to NCQA review – if delegate if NCQA accredited/certified, client receives auto-credit for files
• Plan/MBHO reports universe to NCQA as part of survey process
• NCQA selects random sample – notifies plan 10 business days before onsite of selected samples
• During onsite surveyor reviews and scores files for compliance with each element/factor
HEDIS

HEALTHCARE EFFECTIVENESS AND DATA INFORMATION SET
HEDIS

80 Measures over 5 Domains of Care

NCQA HP Accreditation uses a select set of HEDIS measures

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization & Relative Resource Use
- Health Plan Descriptive Information
HEDIS Scoring

HEDIS scores are based on the percentage of members who meet requirements as shown in specifications. The score for each measure is then compared to other health plans (by product) and percentiles established. The total HEDIS score is based on where the HP falls in the percentiles.
HEDIS Measures

- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Adolescent Well Care
- Adult BMI*
- Adult Access to Preventive/Ambulatory Health Services and Ambulatory Care
- Annual Dental Visit
- Annual Monitoring of Patients on Persistent Medications
- Antibiotic Utilization
- Antidepressant Medication Management*
- Appropriate Testing for Children w/ Pharyngitis*
- Appropriate Treatment for Children with Upper Respiratory Infection*
- Aspirin Use and Discussion
- Asthma Medication Rates
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis*
- Board Certification

- Breast Cancer Screening*
- CAHPS Health Plan survey
- Call Answer Timeliness
- Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia
- Care for Older Adults
- Cervical Cancer Screening*
- Childhood Immunization Status*
- Children Adolescent Access to Primary Care Practitioners
- Children with Chronic Conditions
- Chlamydia Screening in Women*
- Cholesterol Management for Patients with Cardiovascular Conditions*
- Colorectal Screening
- Comprehensive Diabetes Care*
- Controlling High Blood Pressure*
- Diabetes Monitoring for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Meds
HEDIS Measures

- Disease-Modifying Anti-Rheumatic Drug Therapy
- Enrollment by Product Line
- Enrollment by State
- Fall Risk Management
- Flu Shots
- F/U After Hospitalization for Mental Illness*
- F/U for Children Prescribed ADHD Medications*
- Glaucoma Screening in Older Adults
- HPV for Female Adolescents
- ID of Alcohol and Other Drug Services
- Immunizations for Adolescents
- Initiation and Engagement of Alcohol and Other Drug Dependencies Treatment
- Inpatient Utilization
- Language Diversity of Membership
- Lead Screening in Children
- Management of Urinary Incontinence in Older Adults
- Medical Assistance with Smoking and Tobacco Use Cessation*
- Medicare Health Outcomes Survey
- Medication Management for People with Asthma
- Medication Reconciliation Post Discharge
- Mental Health Utilization
- Osteoporosis Management in Women who had a Fracture
- Osteoporosis Testing in Older Women
- Persistence of Beta Blocker Treatment after a Heart Attack
- Pharmacotherapy Management of COPD Exacerbation*
- Physical Activity in Older Adults
- Plan All-Cause Readmission
- Pneumococcal Vaccination Status for Older Adults
- Potentially Harmful Drug-Disease Interactions in the Elderly
- Prenatal and Postpartum Care*
- Race/Ethnicity Diversity of Membership
- Relative Resource Use (RRU) of People with Asthma
- RRU for People with Cardiovascular Conditions
HEDIS Measures

- RRU for People with COPD
- RRU for People with Diabetes
- RRU for People with Hypertension
- Total Membership
- Use of Appropriate Medications for People with Asthma*
- Use of High-Risk Medications in Elderly
- Use of Imaging Studies for Low Back Pain*
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD*
- Weeks of Pregnancy at Time of Enrollment
- Weight Assessment and Counseling for Children/Adolescents*
- Well Child Visits in the First 15 Months of Life
- Well Child Visits in the 3rd, 4th, 5th and 6th Years of Life

- Performances on measures indicated with * count toward Medicaid accreditation status
- Behavioral health measures shown in red
“What gets measured, gets improved”
CAHPS

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS
CAHPS

- Standardized surveys (Adult, Child, Child w/Chronic Condition) that measure patient satisfaction with the experience of care
- Sponsored by the Agency for Health Care Research and Quality (AHRQ)
- Global rating questions reflect overall satisfaction
  - Rating of All Health Care
  - Rating of Health Plan
  - Rating of Personal Doctor
  - Rating of Specialist Seen Most Often
CAHPS

Seven composite scores summarize responses in key areas

• Customer Service
• Getting Care Quickly
• Getting Needed Care
• How Well Doctors Communicate
• Shared Decision making
• Plan Information Costs
• Claims Processing (Commercial only)
CAHPS Measures used for Medicaid Accreditation Score

- Getting Care Quickly
- Getting Needed Care
- Customer Service
- Rating of Health Plan (counts double)
- How Well Doctors Communicate
- Rating of All Health Care
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often
Improved HEDIS Results = IHI Triple Aim

• Improving patient experience of care
• Improving the health of the managed care population
• Reducing the per capita cost of health care
NCQA STANDARDS
NCQA Standards

Health Plan Standards

• Quality Management and Improvement (QI)
• Utilization Management (UM)
• Credentialing and Recredentialing (CR)
• Members Rights and Responsibilities (RR)
• Member Connections (MEM)
• Medicaid Benefits and Services (MED)

MBHO Standards

• Quality Management and Improvement (QI)
• Care Coordination (CC)
• Utilization Management (UM)
• Credentialing and Recredentialing (CR)
• Members Rights and Responsibilities (RR)
A Standard’s Structure

**QI 3: Health Services Contracting—Refer to Appendix 1 for points**

The organization’s contracts with individual practitioners and providers, including those making UM decisions, specify that contractors cooperate with its QI program.

**Intent**
The organization’s contracts with practitioners and providers foster open communication and cooperation with QI activities.

**Summary of Changes**
- NCQA revised and updated the Standards and Guidelines. Changes to this standard’s requirements, if any, are listed here. Please refer to Appendix 10 for more information.

**Element A: Practitioner Contracts—Refer to Appendix 1 for points**
Contracts with practitioners specifically require that:
1. Practitioners cooperate with QI activities.
2. Practitioners maintain the confidentiality of member information and records.
3. Practitioners allow the organization to use their performance data.

**Scoring**

<table>
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<tr>
<th>100%</th>
<th>80%</th>
<th>50%</th>
<th>20%</th>
<th>0%</th>
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<tr>
<td>The organization meets all 3 factors</td>
<td>The organization meets 2 factors</td>
<td>No scoring option</td>
<td>The organization meets 1 factor</td>
<td>The organization meets 0 factors</td>
</tr>
</tbody>
</table>

**Data source**
Materials

**Scope of review**
This element applies to Interim Surveys, First Surveys and Renewal Surveys.
- For Interim Surveys: NCQA reviews one primary care contract and one specialist contract. The contracts do not need to be executed.
- For First Surveys and Renewal Surveys: NCQA reviews three active primary care contracts and three specialist contracts executed within the look-back period.

**Look-back period**
- For Interim Surveys: Prior to the survey date.
- For First Surveys: 6 months.
- For Renewal Surveys: 24 months; 12 months for factor 3.

**Explanation**
This element is a structural requirement. The organization must present its own materials.

This element applies to contracts between the organization and its practitioners, medical groups, independent practice associations (IPA) and dental networks.

**Providing the contract for review**
The organization may attach the entire contract or only the relevant pages from the contract that address this element (e.g., the first page with the practitioner name, text that meets the factors and the signature page) when it submits the completed Survey Tool or may have the documents reviewed on site.

Effective for Surveys Beginning On or After July 1, 2015

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A Standard’s Structure - Terminology

- **Standard statement** – acceptable performance or results
- **Intent statement** – goal of the statement
- **Summary of changes** – revisions from previous year
- **Element** – the scored component – details about performance expectations
- **Factor** – item within an element
- **Scoring** – level of performance to be demonstrated for 100%, 80%, 50%, 20%, 0%
A Standard’s Structure – Terminology

Data Sources

• Documented process
  – How something is done, P&P, flowchart, protocols

• Reports
  – Evidence of compliance, program evaluation, summary reports, minutes

• Materials
  – Evidence of information provided to members, providers, others, websites, scripts, brochures, CPGs, contracts

• Records or Files
  – Denials, Appeals, Complex Case Management, Credentialing/Recredentialing
A Standard’s Structure – Terminology

- **Scope of review** – extent of services evaluated during survey
- **Look-back period** – period for which compliance must be demonstrated – varies by type of survey, new elements, factors, etc.
- **Explanation** – specific requirements and guidance
- **Exception** – instances in which element/factor may not be applicable
- **Examples** - guidance
Delegation

- Delegation - An organization gives an entity the authority to perform certain functions on its behalf – delegating entity retains responsibility
- Prior to delegation, health plan must assess delegate’s ability to perform according to standards (pre-delegation evaluation)
- Delegation agreement must describe delegated activities and responsibilities, require regular reporting, describe how health plan evaluates the delegate’s performance, and remedies available if obligations are not fulfilled
- Health plan must provide member experience data and clinical performance data to delegate upon request
- Entities must agree to provisions for PHI
QUALITY MANAGEMENT
AND IMPROVEMENT
QI Standards

• QI Program – Annual QI Program Description, QI Workplan, Evaluation of QI Program
• QI Committee functions
• Contracting with practitioners and providers
QI Standards

• **Access and Availability**

• **Quantifiable and measureable standards for:**
  • Number of each type of practitioner (usually ratios)
  • Geographic distribution of each type (practitioner and provider)

• **Standards for access to behavioral health care:**
  • Care for non-life-threatening emergency within 6 hours
  • Urgent care within 48 hours
  • Appointment for routine visit within 10 business days
  • BH telephone service – screening and triage ASA within 30 seconds and AR <5%

• **Annual assessment of performance against standards**
QI Standards

• Member experience
• Clinical Practice Guidelines
• Monitoring of continuity and coordination of care
• Management of continued access to practitioners and assistance with care transition
QI Standards

• Complex Case Management
  • A program of coordinated care and services for organization members who have experienced a critical event or diagnosis that requires extensive use of resources
  • Goal – help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner
  • Includes proactive identification of eligible members, comprehensive assessment, plan of care, structured follow up, integrated with other departments/services
  • Evaluate program through 3 measures of effectiveness, plus member experience
  • Compliance with standards evaluated through file review of actual cases
UTILIZATION MANAGEMENT
UM Standards

- UM Program Description and Annual Program Evaluation
- Criteria for UM decision-making and procedures for applying criteria
- Annual inter-rater reliability testing for application of criteria
- Member and Practitioner access to staff to discuss UM issues
- Assessment of member and practitioner experience with UM
UM Standards

- Precise process for level of staff involved in UM decision-making
- Only physician or doctoral level BH practitioner can make UM medical necessity denial
- Strict timelines for decision-making
- Denial letter must include reason for denial, criteria on which decision based, offer to provide criteria upon request, description of appeal rights
- Compliance with standards evaluated through file review of actual denials
UM Standards

- Process for appeal of UM denials, with prescribed timeliness, review by new reviewer, member rights
- Appeal decision letter must include reason for decision, criteria on which decision based, offer to provide criteria upon request, description of further appeal rights
UM Standards

• Must cover emergency services to screen and stabilize without prior approval
• If triage and referral required for BH services, must have clinically based protocols and use of licensed practitioners to make decisions that require clinical judgment
CREDENTIALING AND RECRECREDENTIALING
CR Standards

• Well-defined credentialing process with specific criteria, verification sources and process
• Physician responsible for credentialing process
• Credentialing committee includes participating practitioners
• Recredentialing conducted at least every three years
• Compliance with standards evaluated through file reviews
CR Standards

• Standards for the quality of practitioners offices – accessibility, appearance, space, medical record-keeping
• Ongoing monitoring of Medicare/Medicaid sanctions, license limitations/sanctions, member complaints, adverse events
CR Standards

• Process for notification to authorities regarding practitioner termination/suspension due to quality concern
• Process for review of status of organizational providers – regulatory and accreditation status – applies to inpatient, residential or ambulatory BH services
MEMBERS’ RIGHTS
AND RESPONSIBILITIES
RR Standards

- Statement of members’ rights and responsibilities, with distribution to members and practitioners
- Defined process for management of member complaints and (non-medical necessity) appeals
- Notification to members of processes to understand coverage and obtain care
RR Standards

• Online provider directory – searchable, validated, frequently updated

• Defined privacy and confidentiality policies and processes
  • Similar to HIPAA requirements; annual privacy notice
  • Includes management physical and electronic access to sensitive information
  • Chief Privacy Officer/Privacy Committee responsible and accountable for protection of information, policies, levels of user access, mechanisms to identify unnecessary PHI collections and to limit access to PHI
MBHO vs. HP Standards

• Standards for self-management tools in MBHO QI section (no MEM in MBHO)

• Use of technology to improve care coordination (in Care Coordination section for MBHO, in MEM for HP)
  – Support or facilitate e-visits, e-appointment scheduling, refill reminders, e-referrals, e-enrollment in case management or wellness programs, online personal health records
MBHO vs. HP Standards

- Outcomes for HP measured through HEDIS/CAHPS
- MBHO – annually identify and collect/analyze data on 3 relevant clinical issues
- Must annually monitor clinical performance on selected conditions
- Must demonstrate meaningful improvement in two areas of clinical care and two areas of service
Unique MBHO Standard

• Behavioral Health Screening – implement at least two screening programs that address coexisting mental health and substance use disorders
MBHO Survey Process and Scoring

- Can receive Full Accreditation with 84-100 points
- Certain standards are considered “core” and must be met
- Must pass elements – must score >20% on:
  - QI 3B – contracts allow free discussion of treatment options
  - UM 4C – appropriate professional reviewed denial
  - UM 7 B and C – written notification of denial and right to appeal
  - UM 9D – appropriate notification of appeal decision
- NCQA reviews UM denials and appeals only if delegated to MBHO by one or more clients
QUESTIONS?

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NCQA INFORMATION: http://www.ncqa.org