IMPAQ INTERNATIONAL

Memorandum

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Re: Summary of Findings: Comparison of NCQA Accreditation Standards with Federal and State Medicaid Requirements

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The California Department of Health Care Services (DHCS) is exploring whether, and how, it might leverage the National Committee for Quality Assurance (NCQA) Accreditation process to reduce or eliminate duplicative oversight responsibilities for its Medicaid managed care plans (MCPs).

NCQA's accreditation process uses a series of standards to evaluate the extent to which health plans deliver high-quality care, monitor internal operations, and continually evaluate their performance. NCQA evaluates plans based on the following sets of standards:

- Quality Management and Improvement
- Population Health Management
- Network Management
- Utilization Management
- Credentialing and Recredentialing
- Member Experience
- Long-term Services and Supports (the "LTSS module," for plans that offer long-term care)
- Medicaid Benefits and Services (the "MED module," applicable for Medicaid plans only)

Each set of standards contains elements and factors. Below we provide an example from the Quality Management and Improvement, Standard 1, Program Structure and Operations:

	Standard	Elements	Factors
Quality Management and Improvement	Program Structure and Operations	A. QI Program Structure	• Program structure • Behavioral healthcare • Involvement of designated physician • Involvement of designated behavioral healthcare practitioner • QI Committee oversight • Serving a diverse membership
		B. Annual Work Plan	• Yearly planned QI activities and objectives • Time frame for each activity's completion • Staff members responsible for each activity • Monitoring of previously identified issues • Evaluation of the QI program
		C. Annual Evaluation	• Completed and ongoing QI activities • Trending of QI measure results • Analysis and evaluation of effectiveness
		D. QI Committee Responsibilities	• Policy recommendations • Analysis and evaluation of QI activities • Practitioner participation • Identify needed actions • Follow-up

Certain elements and factors map to federal Medicaid managed care regulations. Plans that meet these elements and factors through the NCQA accreditation process are simultaneously demonstrating their compliance with a subset of Medicaid managed care regulations. Therefore the accreditation review can serve as the basis for exercising the non-duplication option at 42 CFR §438.360.

Currently, DHCS audits its MCPs, but does not deem the results through an accrediting entity. DHCS requested that IMPAQ analyze NCQA accreditation standards in relation to federal and state Medicaid regulations to identify potential areas where the state could potentially exercise the non-duplication option.

Our Approach

To conduct this analysis, IMPAQ began by comparing each NCQA Accreditation standard to Federal Medicaid Regulations (42 CFR §438), using the NCQA Medicaid Managed Care Toolkit—a document that maps Medicaid managed care regulations to specific NCQA standards—to guide this review. We reviewed the contents of each standard, element, and factor to determine whether, and to what extent, the NCQA standard aligned with the federal regulation. If a standard completely aligned with the regulation, we considered the standard to be met. If a standard only partially aligned

with the regulation, we considered it partially met and documented the parts of the standard that did not align. For standards that did not align with federal regulation (that is, the NCQA standard was less stringent, or was substantively different), we indicated that it was not met and documented the reason for non-alignment.

We repeated a similar process when reviewing state regulations (Title 22, Title 28, Welfare and Institutions Code, and the Health and Safety Code). However, because the state regulations often augment or clarify the federal Medicaid regulations (but do not duplicate them), certain NCQA standards tend to align only with a federal regulation.

We provided DHCS with a detailed Comparison Chart that identifies areas where federal and state regulations could be deemed through NCQA accreditation and where gaps exist such that deeming would not be feasible.

For example, NCQA accreditation standards meet the federal Medicaid requirements pertaining to adequate capacity of providers (42 CFR §438.207) to serve the expected enrollment of MCPs, which suggests that if MCPs were required to attain NCQA accreditation, the state could use the accreditation status as evidence (or deem) that they fulfilled this federal requirement. However, NCQA accreditation standards do not require MCPs to conduct performance improvement projects, which are a federal requirement under 42 CFR §438.330. In this case, NCQA accreditation alone would not be sufficient to deem this requirement, as the state would still be required to review performance improvement projects.

The remainder of this memo provides a high-level summary of the findings from the Comparison Chart, categorized into three main areas: (1) Federal Requirements that are potentially deemable; (2) Federal requirements that are not likely to be deemable; and (3) Federal requirements that need further analysis of current state requirements or the NCQA review process to make a determination on deeming. For additional context, we also provide insights from our structured discussions with two states that require NCQA accreditation for the MCPs.

1. Requirements that are potentially deemable—Key Findings

Federal and state regulations that are potentially deemable pertain to information requirements, access to care, structure and operations, quality improvement, and grievances and appeals. NCQA accreditation standards exceed the majority of federal requirements under §438.10 (Information Requirements) and a majority of related state requirements. These deemable regulations pertain to the way MCPs communicate information to current and potential enrollees on covered benefits, providers, eligibility, grievances, and other related plan information (see Table 1).

Similarly, NCQA accreditation standards meet a majority of federal and state requirements pertaining to the availability of services and network adequacy (§438.206) and care coordination (§438.208). Regulations pertaining to grievances and appeals may be deemed at the federal level as NCQA standards address grievance and appeal procedures within the Utilization Management, Member Experience, and Medicaid modules. However we recommend a closer analysis of NCQA standards as they relate to DHCS regulations, as many of the state's requirements are significantly different from NCQA standards.

Table 1. Federal and State Requirements that are Potentially Deemable through NCQA Accreditation *(Potentially Deemable=YES for both federal and state)*

Federal Regulation	Description	Potentially Deemable at Federal Level?	Potentially Deemable at State Level?
Information Requirements			
§438.10(c)(1)	Information requirements - Basic rules	YES	YES
§438.10(c)(6)	Format of enrollee information	YES	YES
§438.10(c)(7)	Mechanisms to help enrollees and potential enrollees understand the requirements and benefits of the plan	YES	YES
§438.10(d)(1-4)	Information requirements - Non-English resources	YES	YES
§438.10(d)(5)	Information requirements - Non-English resources	YES	YES
§438.10(d)(6)	Information requirements - Written materials	YES	YES
§438.10(f)(1)	Information requirements - Termination notice	YES	YES
§438.10(g)(1)	Information requirements - Enrollee Handbook	YES	YES
§438.10(g)(2)(i-iv)	Information requirements - Enrollee Handbook	YES	YES
§438.10(g)(2)(v)	Information requirements - After-hours/ emergency coverage	YES	YES
§438.10(g)(2)(vii)	Information requirements - Obtaining OON benefits, including family planning services	YES	YES
§438.10(g)(2)(viii)	Information requirements - Cost sharing	YES	YES

Federal Regulation	Description	Potentially Deemable at Federal Level?	Potentially Deemable at State Level?
§438.10(g)(2)(ix)	Information requirements - Enrollee rights and protections	YES	YES
§438.10(g)(2)(xi)(A-B)	Information requirements - Right to file grievances and appeals and timeframes	YES	YES
§438.10(g)(2)(xi)(D-E)	Information requirements - Right to request hearing; continuation of benefits during a pending appeal	YES	YES
§438.10(g)(2)(xii)	Information requirements - Advance directives	YES	YES
§438.10(g)(2)(xiii)	Information requirements - Auxiliary aids and services	YES	YES
§438.10(g)(2)(xiv)	Information requirements - Toll-free numbers	YES	YES
§438.10(g)(2)(xv)	Information requirements - How to report suspected fraud or abuse	YES	YES
438.10(h)(1-3)	Updating of provider directories	YES	YES
438.10(i)	Formulary content and format	YES	YES
Access to Care – Emergency and Post-Stabilization Services			
§438.114(c)(1)(ii)	Denial of payment for emergency services	YES	YES
§438.114(d)(1-3)	Rules for emergency services	YES	YES
Access to Care - Coordination and Continuity of Care			
§438.206(b)(1)	Maintains and monitors network of appropriate providers	YES	YES
§438.206(b)(2)	Provides female enrollees with direct access to a women's health	YES	YES

Federal Regulation	Description	Potentially Deemable at Federal Level?	Potentially Deemable at State Level?
	specialist within the provider network		
§438.206(b)(3)	Provides for a second opinion from a network provider, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee	YES	YES
§438.206(b)(4)	If the network provider is unable to provide necessary services, covered under the contract, to a particular enrollee, the MCO, PIHP, or PAHP must adequately and timely cover these services out of network for the enrollee	YES	YES
§438.206(b)(5)	Requires out-of-network providers to coordinate with the MCO, PIHP, or PAHP for payment and ensures the cost to the enrollee is no greater than it would be if the services were furnished within the network	YES	YES
§438.206(b)(7)	Demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services	YES	YES
§438.206(c)(1)(i)	Meet and require its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services	YES	YES
§438.206(c)(1)(ii-iii)	Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees, Make services included in the contract available 24 hours	YES	YES

Federal Regulation	Description	Potentially Deemable at Federal Level?	Potentially Deemable at State Level?
	a day, 7 days a week, when medically necessary		
§438.206(c)(1)(iv-vi)	Establish mechanisms to ensure compliance by network providers. Monitor network providers regularly to determine compliance. Take corrective action if there is a failure to comply by a network provider.	YES	YES
§438.206(c)(2)	Access and cultural considerations	YES	YES
438.208(b)(1)	Care and coordination of services for all MCO, PIHP, and PAHP enrollees.	YES	YES
§438.208(b)(2)	Care coordination of services through other plans	YES	YES
438.208(b)(3)	Provide for initial screening	YES	YES
438.208(b)(4)	Share results with state	YES	YES
§438.208(b)(5)	Ensure providers share health records	YES	YES
438.208(b)(6)	Ensure enrollee's privacy is protected during coordination of care	YES	YES
438.208(c)(2)	Assessment for enrollees with special health care needs or need LTSS	YES	YES
438.208(c)(3)(i-ii, iv-v)	Service plan for enrollees with LTSS needs	YES	YES
438.208(c)(4)(iii)	Direct access to specialists for enrollees with special health care needs	YES	YES

Federal Regulation	Description	Potentially Deemable at Federal Level?	Potentially Deemable at State Level?
Access to Care - Coverage and Authorization of Services			
§438.210(a)(3)(ii)	Coverage: May not deny or reduce the amount duration or scope of service	YES	YES
§438.210(a)(4)(i)	Coverage: Limits on service on basis of criteria such as medical necessity	YES	YES
§438.210(a)(5)(i)	Specifying medically necessary services	YES	YES
§438.210(b)(2)	Review criteria for authorization of services	YES	YES
§438.210(b)(3)	Decision to approve or deny service may be made by individual with expertise	YES	YES
§438.210(c)	Written notice of denial	YES	YES
Structure and Operations – Provider Selection			
§438.214 (b)(2)	Credentialing and recredentialing requirements	YES	YES
§438.214 (c)	Nondiscrimination	YES	YES
§438.230 (b)	Subcontractual relationships and delegation	YES	YES
§438.230 (c) (1) (i-iii)	Subcontractual relationships and delegation	YES	YES
Structure and Operations - Confidentiality			
§438.224 (-)	Confidentiality	YES	YES
Quality Measurement and Improvement - Practice Guidelines			
§438.236 (b)	Adoption of practice guidelines	YES	YES

Federal Regulation	Description	Potentially Deemable at Federal Level?	Potentially Deemable at State Level?
§438.236 (c)	Dissemination of guidelines	YES	YES
§438.236 (d)	Application of guidelines	YES	YES
Quality Measurement and Improvement - Quality Assessment and Performance Improvement Program			
§438.330(a)(1)	Implement an ongoing comprehensive quality assessment and performance improvement program	YES	YES
§438.330(b)(3-4)	Mechanisms to detect under- and overutilization and appropriateness of care	YES	YES
§438.330(c)(2)	Measure and report to the State on its performance	YES	YES
§438.330(e)(2)	Evaluate the impact of the plan's quality QAPI	YES	YES
Grievances – General Requirements			
§438.402(b)	Level of appeals	YES	YES
§438.402(c)	Filing requirements	YES	YES
Grievances – Timely and adequate notice of adverse benefit determination			
§438.404(a)	Timely and adequate notice of an adverse benefit determination in writing	YES	YES
§438.404(c)(2)	Timing of notices related to termination, suspension, or reduction of services	YES	YES
Grievances – Handling of grievances and appeals			
§438.406(b)(1-6)	Special requirements for handling grievances and appeals	YES	YES

Federal Regulation	Description	Potentially Deemable at Federal Level?	Potentially Deemable at State Level?
Grievances – Resolution and notification: Grievances and appeals			
§438.408(d)(2)	Format of appeals notices	YES	YES
§438.408(e)(1)	Content of appeal resolutions	YES	YES
Grievances – Expedited resolution of appeals			
§438.410(a)	Expedited review process for appeals	YES	YES
§438.410(c)(1-2)	Action following denial of request for expedited resolution	YES	YES
§438.414	Distribution of information on appeals and grievances	YES	YES
Grievances – Recordkeeping requirements			
§438.416(a)	Records of grievances and appeals	YES	YES
Grievances – Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State fair hearing are pending			
§438.420(a)(i-ii)	Timeliness of filing of appeals	YES	YES

2. Requirements that are not likely to be deemable—Key Findings

We identified 6 instances where the NCQA standards did not meet both federal and state requirements. The regulations identified below, such as machine-readable provider directories and protections for members who file grievances, would not be met unless NCQA incorporated these elements into the accreditation standards.

Table 2. Federal and State Requirements that are not likely to be Deemable through NCQA Accreditation *(Potentially Deemable=NO for both federal and state)*

Federal Regulation	Description	Potentially Deemable at Federal Level?	Potentially Deemable at State Level?
Information Requirements			
§438.10(g)(4)	Information Requirements - Notice of significant changes	NO	NO
§438.10(g)(h)	Information Requirements - Machine readable provider directories	NO	NO
Access to Care - Coordination and Continuity of Care			
§438.208(c)(3)(iii)	Approval of care plans by the MCO	NO	NO
Access to Care - Coverage and Authorization of Services			
§438.210(a)(5)(ii)	Plan contracts must specify the types of covered services	NO	NO
Grievances			
§438.404(c)(1)	Timing of notices related to termination, suspension, or reduction of services	NO	NO
§438.410(b)	Punitive action toward providers	NO	NO

3. Requirements that need further analysis—Key Findings

Among the remaining federal regulations that we assessed for potential deeming through NCQA accreditation, we identified three main areas where the NCQA standard may enable the state to deem the requirements, but would require additional compliance review (Table 3).

Table 3. Federal and State Requirements that Require Further Analysis
(Potentially Deemable=MAYBE for either federal or state)

Federal Regulation	Description	Potentially Deemable at Federal Level?	Potentially Deemable at State Level?
Access to Care - Coverage and Authorization of Services			
§438.210(e)	Compensation for utilization management activities	MAYBE	YES
Quality Measurement and Improvement – Health Information Systems			
§438.242(a)	Quality Measurement and Improvement – Health Information Systems	MAYBE	YES
Grievances			
§438.406(a)	Providing assistance to members for completing forms and other grievance/appeal steps	MAYBE	YES

Observations from discussions with two states—Washington and Tennessee

In addition to the deeming assessment, IMPAQ and DHCS also conducted structured discussions with two states (Washington and Tennessee) to glean insights about their experiences with NCQA accreditation and deeming. Both states require their MCPs to be NCQA accredited and uses the Health Plan Accreditation (HPA) Standards (it does not require the MED or LTSS modules). Washington does not leverage accreditation to deem federal or state Medicaid requirements. In 2016, the state evaluated deeming options and determined that it prefers a more "hands-on" approach with respect to grievances and appeals, quality improvement, and monitoring. To ensure that MCPs comply with federal and state requirements, Washington conducts an Annual Review. Each year a different set of criterion are reviewed on a 3-year cycle, but the state has flexibility to include additional topics that require more frequent monitoring. For example, prior authorization processes and grievances are subject to a detailed file review. NCQA Accreditation has allowed Washington to shift attention to monitoring certain areas more closely and stepping back when the NCQA is also able to provide oversight. This has allowed Washington to streamline their contract in some areas (e.g., credentialing). Because the state's Medicaid program has changed since the initial analysis in 2016, and Washington is considering reviewing NCQA deeming opportunities.

Tennessee also requires its MCPs to achieve NCQA accreditation, using both the HPA and LTSS standards. The state leverages NCQA accreditation to deem certain requirements, but to a very limited extent. For example, the state recently began

requiring population health management in its Medicaid contracts, and deems a subset of those requirements through the Population Health Management standards. Deemed areas are identified in the state's Medicaid Managed Care Quality Strategy. However staff from Tennessee indicated that it deems only certain elements and prefers to maintain oversight of most managed care requirements. Although the state has not specifically identified areas that it would not consider deeming, staff cited network adequacy as an area that they prefer to oversee directly.

Conclusion

This summary is intended to serve as a basis for identifying potential opportunities for deeming. We note that areas we have identified in our crosswalk as potential deeming opportunities remain subject to DHCS review. Final determinations about deeming would need to be confirmed a complete regulatory review to ensure compliance with federal and state laws and regulations. We look forward to supporting DHCS as it continues to explore its options with respect to NCQA accreditation.