NCQA Health Plan Accreditation: Population Health Management Standards Category

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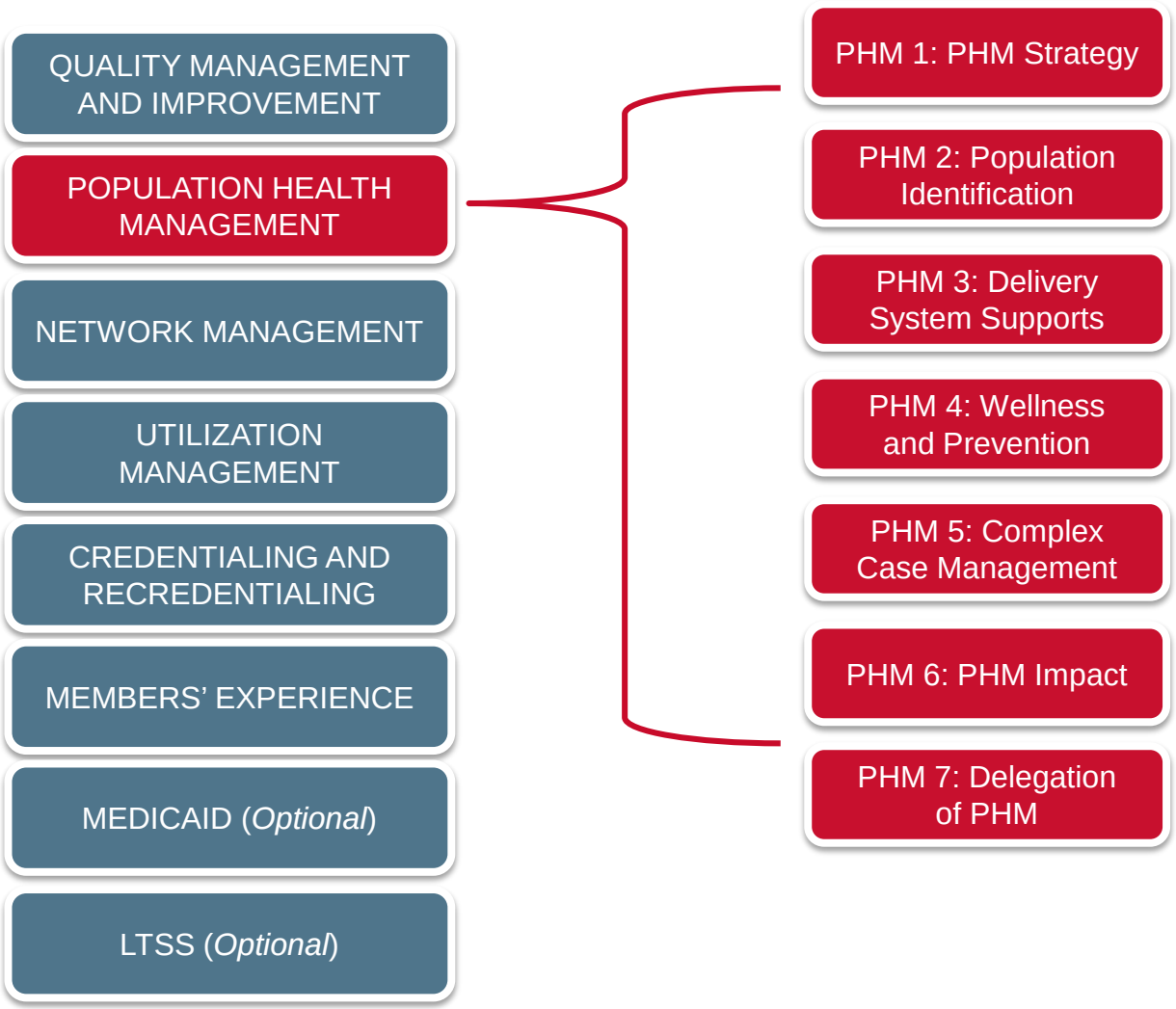
What is population health management?

A model of care that strives to address patients' health needs at all points along the continuum of care, including the community setting, by increasing patient participation and engagement and targeting interventions.

PHM Category in Health Plan Accreditation



PHM 1: PHM Strategy

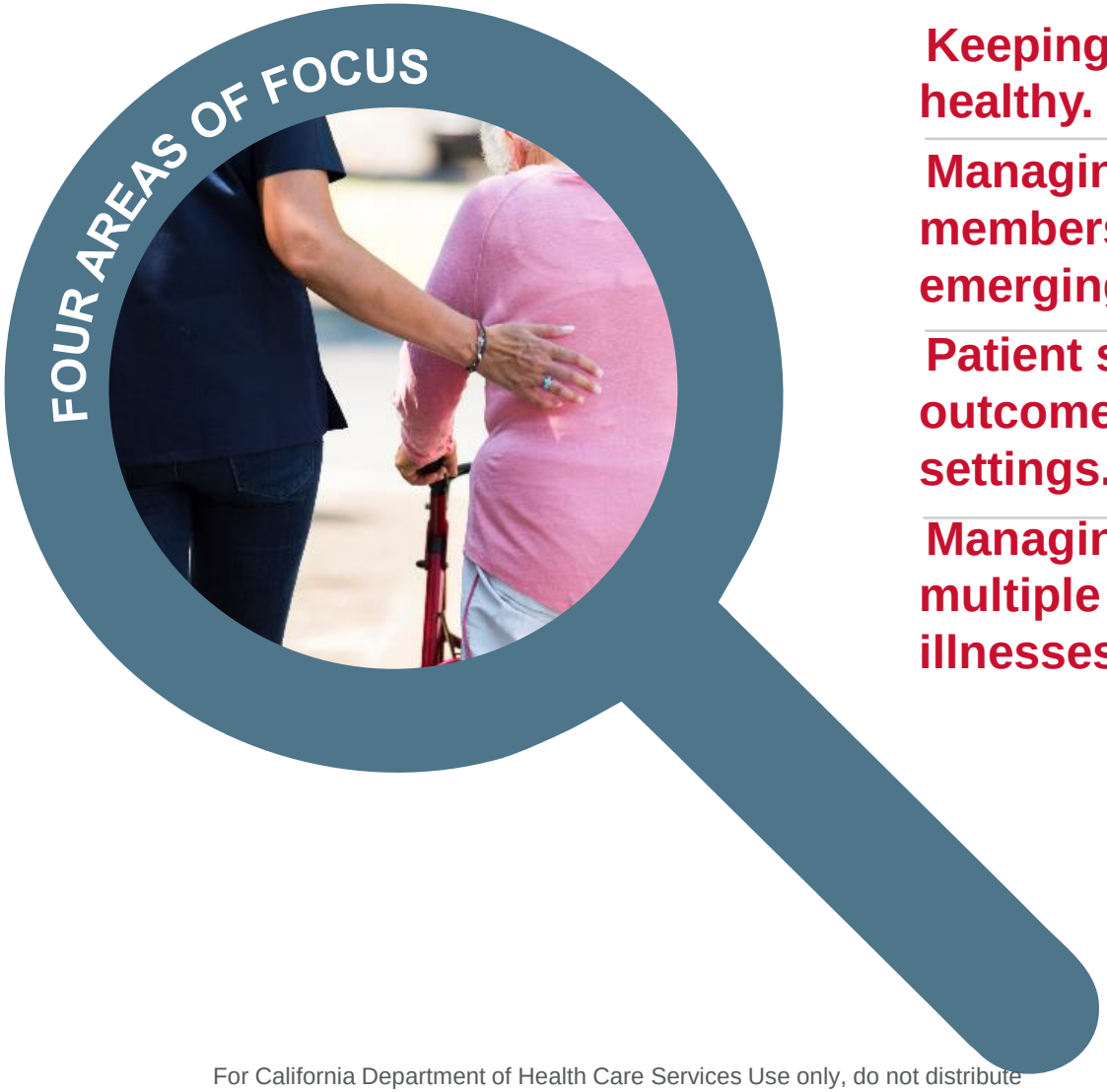
Element A: Strategy Description

Element B: Informing Members

PHM 1A: Strategy Description

The strategy describes:

1. Goals and populations targeted for each of the four areas of focus.
2. Programs or services offered to members.
3. Activities that are not direct member interventions.
4. How member programs are coordinated.
5. How members are informed about available PHM programs.



Keeping members healthy.

Managing members with emerging risk.

Patient safety or outcomes across settings.

Managing multiple chronic illnesses.

PHM 1B: Informing Members

The organization informs members eligible for programs that include interactive contact:

1. How members become eligible to participate.
2. How to use program services.
3. How to opt in or opt out of the program.

PHM 2: Population Identification

Element A: Data Integration

Element B: Population Assessment

Element C: Activities and Resources

Element D: Segmentation

PHM 2A: Data Integration

The organization integrates the following data to use for population health management functions:

1. Medical and behavioral claims or encounters.
2. Pharmacy claims.
3. Laboratory results.
4. Health appraisal results.
5. Electronic health records.
6. Health services programs in the organization.
7. Advanced data sources.

PHM 2B: Population Assessment

The organization annually:

1. Assesses the characteristics and needs, including social determinants of health, of its member population.
2. Identifies and assesses the needs of relevant member subpopulations.
3. Assesses the needs of child and adolescent members.
4. Assesses the needs of members with disabilities.
5. Assesses the needs of members with serious and persistent mental illness.

PHM 2C: Activities and Resources

The organization annually uses the population assessment to:

1. Review and update PHM activities to address member needs.
2. Review and update PHM resources to address member needs.
3. Review community resources for integration into program offerings to address member needs.

PHM 2D: Segmentation

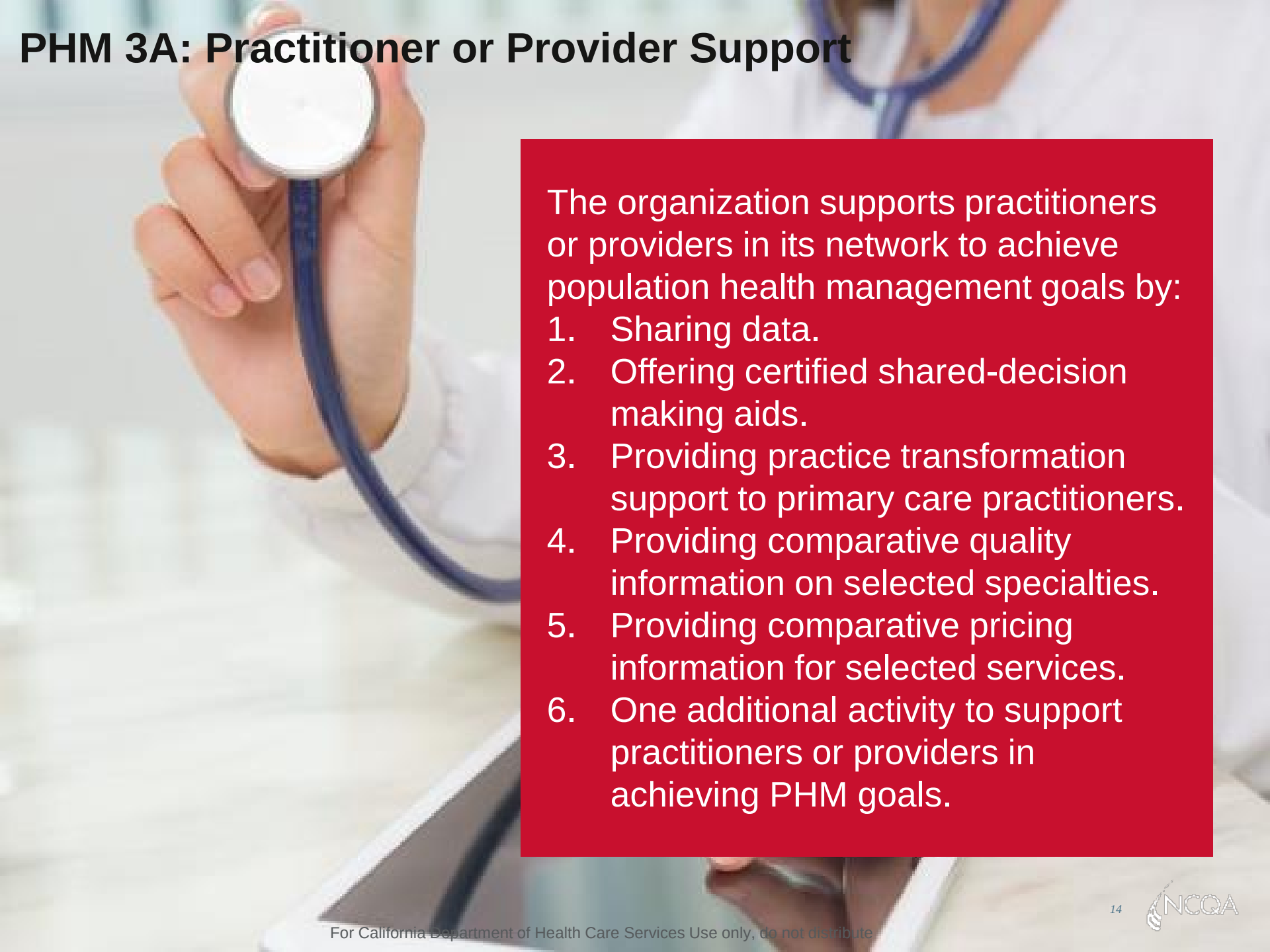
At least annually, the organization segments or stratifies its entire population into subsets for targeted intervention.

PHM 3: Delivery System Supports

Element A: Practitioner or Provider Support

Element B: Value-Based Payment Arrangements

PHM 3A: Practitioner or Provider Support



The organization supports practitioners or providers in its network to achieve population health management goals by:

1. Sharing data.
2. Offering certified shared-decision making aids.
3. Providing practice transformation support to primary care practitioners.
4. Providing comparative quality information on selected specialties.
5. Providing comparative pricing information for selected services.
6. One additional activity to support practitioners or providers in achieving PHM goals.

PHM 3B: Value-Based Payment Arrangements

The organization demonstrates that it has a value-based payment (VBP) arrangement(s) and reports the percentages of total payments tied to VBP.

Must report the *percentage of total payments to providers and practitioners* associated with each type of VBP arrangement:

- **Pay-for-performance**
- **Shared savings**
- **Shared risk**
- **Two-sided risk sharing**
- **Capitation/population-based payment**

Must report at least one to receive credit

Element A: Frequency of Health Appraisal Completion

Element B: Topics of Self-Management Tools

Retired Elements below for HPA 2020:

- *Former Element: Health Appraisal Components.*
- *Former Element B: Health Appraisal Disclosure.*
- *Former Element C: Health Appraisal Scope.*
- *Former Element D: Health Appraisal Results.*
- *Former Element E: Health Appraisal Format.*
- *Former Element G: Health Appraisal Review and Update Process.*
- *Former Element I: Usability Testing of Self-Management Tools.*
- *Former Element J: Review and Update Process for Self-Management Tools.*
- *Former Element K: Self-Management Tools Format.*

PHM 5: Complex Case Management

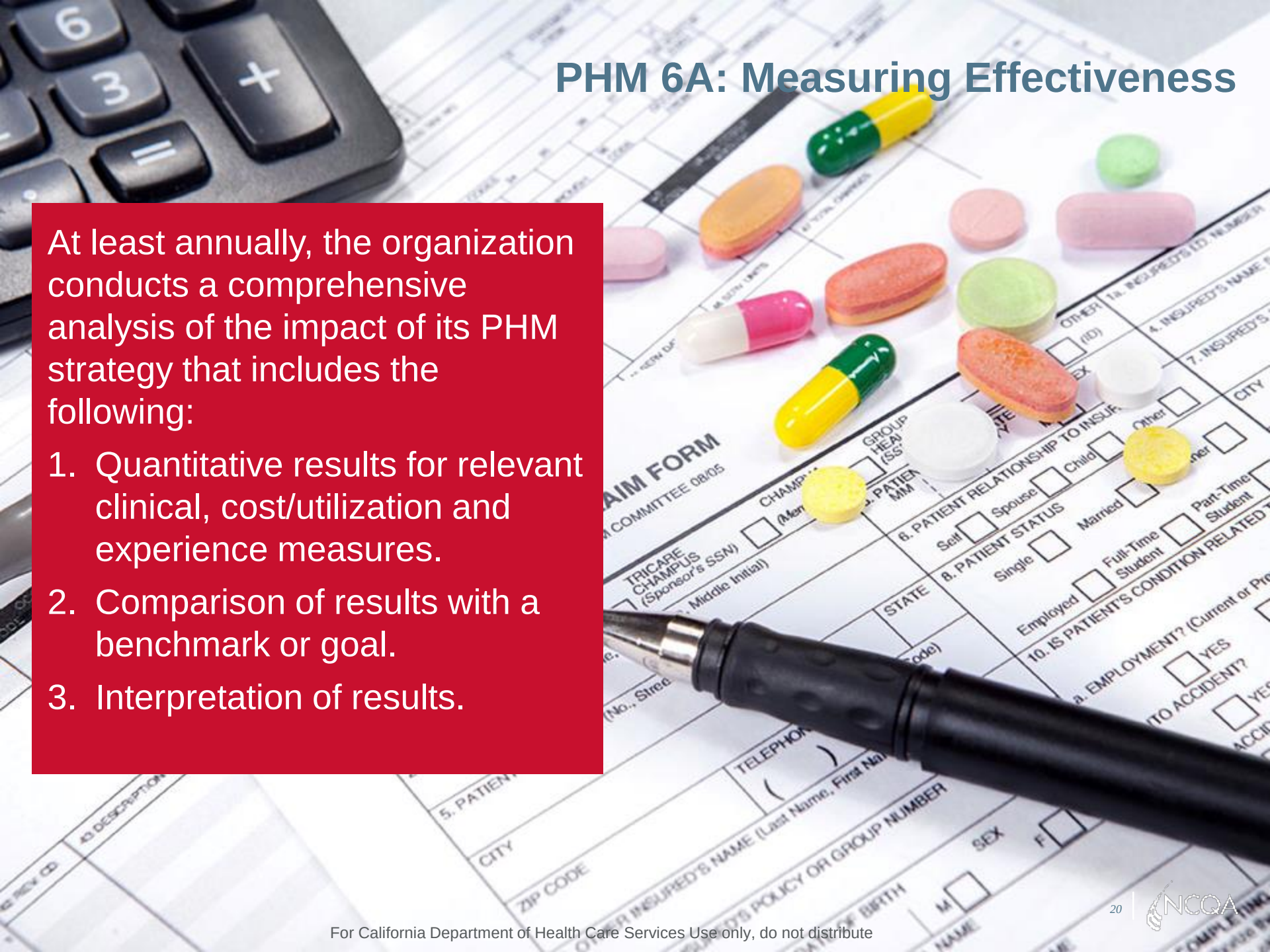
Element A: Access to Case Management
Element B: Case Management Systems
Element C: Case Management Process
Element D: Initial Assessment
Element E: Case Management—Ongoing Management

PHM 6: Population Health Management Impact

Element A: Measuring Effectiveness

Element B: Improvement and Action

PHM 6A: Measuring Effectiveness



At least annually, the organization conducts a comprehensive analysis of the impact of its PHM strategy that includes the following:

1. Quantitative results for relevant clinical, cost/utilization and experience measures.
2. Comparison of results with a benchmark or goal.
3. Interpretation of results.

PHM 6B: Improvement and Action

The organization uses results from the PHM impact analysis to annually:

1. Identify opportunities for improvement.
2. Act on one opportunity for improvement.

Questions