State of California—Health and Human Services Agency

Department of Health Care Services

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DHCS Care Coordination Project: NCQA Accreditation

Background

The National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization that offers accreditation to health plans and other health care related entities (e.g., accountable care organizations) in the areas of: quality improvement, population health management, including complex case management, network management, utilization management, credentialing and re-credentialing, member rights and responsibilities, and member connections. NCQA also develops quality performance measures known as the Healthcare Effectiveness Data and Information Set or HEDIS measures, which provide a standardized method for comparing health plan performance. Currently, 25 states require NCQA accreditation for their contracted Medicaid health plans; four more states recognize it. DHCS does not currently require it, though DHCS does deem Medi-Cal managed care health plans (MCPs) that have NCQA accreditation to be compliant with the credentialing section of the annual DHCS medical compliance audit. As the DHCS care coordination project reviews how it might simplify and standardize the care coordination expectations of the MCPs, consideration is being given to potentially requiring accreditation of MCPs, and in particular accreditation by NCQA, which appears to be the accreditation organization with the most national experience and recognition. The NCQA Population Health Management section of the health plan accreditation guidelines offers a framework that may be consistent with the desired outcomes of the DHCS care coordination project. In addition to the NCQA, there are other national accreditation organizations, as well, such as the Utilization Review Accreditation Commission (URAC), which DHCS could give consideration to requiring. The focus of this discussion document is the advantages and disadvantages of potentially requiring accreditation of MCPs, particularly by NCQA.

Framing the Issue

Many of DHCS' contracted MCPs are already NCQA certified for multiple reasons, including the need to do so for other lines of business. Currently, twelve MCPs have NCQA accreditation or interim accreditation, while an additional six MCPs are in the process of achieving accreditation; that is 18 of 24 currently contracted MCPs. As a result, many MCPs already follow NCQA guidelines with regard to care coordination or population health management. If DHCS required NCQA accreditation and followed the NCQA framework, it could potentially reduce redundancies in care coordination

requirements and increase standardization throughout the state. For example, if DHCS required NCQA accreditation and followed NCQA guidelines when establishing care coordination requirements of MCPs, this could help to eliminate some of the duplicative processes and assessments that DHCS currently requires (e.g., the initial health assessment and the health risk assessment). Further, NCQA accreditation could assist in streamlining the annual medical audit process by increasing the number of categories in which DHCS could consider 'deeming' health plans. In general, feedback from stakeholders is that DHCS should attempt standardization and alignment of any care coordination policy requirements. NCQA has complex case management and population health management requirements already established. If DHCS were to align with those requirements, the expectations and requirements of MCPs could potentially align with other agencies such as Covered California, and further reduce redundancies for the MCPs.

Specific stakeholder feedback is noted below:

- Align policy whenever possible with other relevant agencies and organizations including the Department of Managed Health Care, the NCQA, Medicare and/or Covered California.
- Many other states already required NCQA accreditation, so this would align California with national best-practice standards and allow California to compare MCP performance against national benchmarks.
- Most MCPs are either NCQA certified, or are in the process of becoming NCQA certified. DHCS should redesign care coordination requirements so that they are more predictable with standardized definitions, and since most MCPs are already following NCQA, consider aligning DHCS requirements directly with NCQA requirements.
- Requiring NCQA accreditation would not only help to get everyone on the same page regarding a statewide population health management strategy, but it would relieve some of the state burden of oversight because NCQA would provide review and verification of areas they cover.
- Requiring NCQA accreditation of risk-bearing delegated entities, such as independent practice associations (IPAs), would provide a minimum standard for these entities statewide and relive some MCP burden of review and oversight.
- MCPs want standardized, programmatic definitions when being audited on areas such as complex care management and NCQA would address this issue through the population health management strategy.

Additional Information

- **Accreditation Chart**: See attachment.
- **NCQA Map of States that Require Accreditation**: http://www.ncqa.org/Portals/0/Public%20Policy/Images/Slides/Slide1.JPG?ver=2018-04-23-203204-133
- **NCQA Health Plan Accreditation Requirements**: http://www.ncqa.org/Portals/0/Programs/Accreditation/HPA/2018_HPA_SGs.pdf?ver=2018-02-16-150007-887

Discussion Questions

1. Should DHCS require NCQA accreditation of its MCPs? What are the pros, cons and other issues the department should consider?
2. Should DHCS require accreditation, but allow accreditation by entities other than NCQA?
    a. Would allowing accreditation by different entities be counterproductive to standardizing requirements and expectations of MCPs?
3. Should DHCS require its MCPs to ensure that any subcontractors to whom certain elements of care coordination is delegated are NCQA accredited?
    a. To include both subcontracted MCPs and IPAs to which functions are delegated or only subcontracted MCPs?
    b. If DHCS required NCQA accreditation of its MCPs, should it consider allowing subcontractors of the MCPs to which care coordination is delegated to achieve accreditation through other agencies (e.g., URAC)?
4. How long should DHCS allow for plans that are not NCQA accredited to complete accreditation?
5. If DHCS required NCQA accreditation, should DHCS give thought to aligning other processes with NCQA, including other areas such as utilization management or network management?
6. Would requiring NCQA accreditation change DHCS' monitoring of the MCPs?
    a. Would DHCS potentially allow 'deeming' of additional sections in the annual A&I medical compliance audits? Currently, DHCS allows 'deeming' of the credentialing portion of the audit only for NCQA accredited MCPs.
7. What are the potential implications of an MCP losing its NCQA accreditation? Should DHCS consider corrective action if the MCP does not achieve re-accreditation at the next review? How long should DHCS allow for achieving re-accreditation?