



NCQA Medicaid Managed Care Toolkit 2012 Health Plan Accreditation Standards

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Assistance for State Agencies in Using NCQA Accreditation for Medicaid Managed Care Oversight

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Summary

This toolkit provides guidance to state agencies that oversee Medicaid programs to use information obtained through NCQA Accreditation surveys for the oversight of Medicaid managed care plans.

Federal authority to use private accreditation

Per CFR 438.360, in place of a Medicaid review by the State, its agent, or EQRO, states can use information obtained from a national accrediting organization review for the mandatory external quality review activities.

NCQA standards are similar to federal standards

To highlight where there is consistency, NCQA developed a crosswalk comparing NCQA's Health Plan Accreditation (HPA) standards to the federal Medicaid managed care requirements that fall under mandatory EQRO activities. The crosswalk demonstrates that NCQA standards are on par with a majority of federal requirements covered. States should use the crosswalk to reduce duplicative reviews and streamline oversight of managed care plans.

NCQA partners with state agencies

NCQA's Public Policy staff routinely works with states to address questions about NCQA's Health Plan Accreditation program, reporting audited HEDIS and CAHPS^{®1} results and maximizing accreditation as a component of the state's health plan oversight. It is our hope that state agencies can realize the full benefits of NCQA Accreditation and recognition.

Crosswalk Analysis

The crosswalk analysis includes portions of the language from relevant standards that make up the NCQA 2012 Standards and Guidelines. For a detailed understanding of each standard, element, and factor and how each are evaluated as part of the accreditation process, you will need to obtain the [2012 Health Plan Accreditation Standards and Guidelines](#). States that mandate or recognize NCQA's HP Accreditation program receive a complimentary copy of the Standards each year.

Please review the enclosed documents and contact Kristine Thurston Toppe at Toppe@ncqa.org for more information. We would be more than happy to speak with you in more detail or present this information to your agency.

¹ CAHPS[®] is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

EQRO Mandatory Activities and NCQA Programs

Per CFR 438.360, in place of a Medicaid review by the state, its agent or EQRO, states can use information obtained from a national accrediting organization for the mandatory external quality review activities. The purpose of this document is to outline how NCQA Accreditation can be used to demonstrate compliance with the deemable federal requirements (CFR 438.358(b)). States can also utilize this process to complement quality oversight.

Conduct a review to determine health plans' compliance with state standards

These standards must comply with the federal requirements for quality measurement and improvement, structure and operations, and access to care.

NCQA compared relevant federal requirements with our Health Plan Accreditation standards and found that NCQA standards are similar to a majority of the federal requirements that EQROs review and evaluate. This comparison is found under the *deemable requirements* tab of the crosswalk.

NCQA's *Medicaid Managed Care Crosswalk* provides a detailed breakdown of how the federal requirements compare to NCQA standards and demonstrates areas of duplication. (This is a requirement if your state chooses to incorporate NCQA Accreditation findings into its Quality Strategy).

Validation of performance measures

NCQA's HEDIS Compliance Audit process is consistent with the CMS protocol for validating performance measures. Many states, the federal government (Centers for Medicare and Medicaid Services and the Office of Personnel Management), and other purchasers use HEDIS measures for quality improvement, benchmarking and pay for performance.

Note: *Financial relationship rules prohibit the state from accepting audited data to meet the federal requirements of validating performance measures when the plan has paid for the audit.*

Validation of performance improvement projects (PIP)

Medicaid plans are required to engage in performance improvement projects that must be validated by the EQRO. NCQA stopped directly evaluating health plan quality improvement projects beginning with the 2008 Health Plan Accreditation standards. Instead, NCQA places significant weight on the improvement of HEDIS and CAHPS results in accreditation scoring. **Under the 2012 Health Plan Accreditation we derive 45.86% of the plan's overall score from HEDIS and CAHPS performance.** NCQA believes that improvement in HEDIS and CAHPS results is the most standardized and transparent method for assessing a health plan's quality improvement efforts.

Federal Medicaid Managed Care Standards and NCQA Accreditation

Per CFR 438.360, in place of a Medicaid review by the state, its agent or EQRO, states can use information obtained from a national accrediting organization review for the mandatory external quality review activities.

Through this authority, states can deem NCQA standards as equivalent to state requirements or simply use the information obtained through accreditation surveys to streamline their oversight process.

Deeming NCQA Standards

Federal requirements allow states to deem private accreditation organization standards as equivalent to state standards and outline the equivalent areas in their quality strategy. In 2005, we began producing an annual crosswalk of the NCQA Health Plan Accreditation Standards to the federal Medicaid managed care standards for mandatory EQRO activities. This comparison revealed that a majority of the federal requirements are equivalent or similar² to NCQA's accreditation standards. Over the years, these crosswalks have served as a starting point for the state specific equivalency analyses conducted by state Medicaid programs.

Table 2: Equivalency of Federal Requirements*

Regulation Category	2011 Equivalence	2012 Equivalence
Quality Measurement and Improvement (438.236, 240, 242)	75% of these federal requirements are comparable to NCQA standards	75% of these federal requirements are comparable to NCQA standards
Structure and Operations (438.214, 218, 224, 226, 228, 230)	78% of these federal requirements are comparable to NCQA standards	78% of these federal requirements are comparable to NCQA standards
Access to Care (438.206, 207, 208, 210)	82% of these federal requirements are comparable to NCQA standards	82% of these federal requirements are comparable to NCQA standards

*Based on 2012 NCQA Health Plan Accreditation.

The percentages listed in Table 2 include NCQA standards that are directly equivalent to federal requirements, as well as standards that meet the intent with some variation.

Increasing the Value of Accreditation – New Voluntary Medicaid Requirements

In 2011, NCQA added a voluntary standard to address requirements applicable only to Medicaid health plans. This additional standard can help streamline a state Medicaid office's review of Medicaid health plan structure and processes. The Medicaid standard includes the following five requirements relating to benefits and services provided:

- MED 1A: Direct Access to Women's Health Services
- MED 1B: Second Opinions
- MED 1C: Out-of-Network Services
- MED 1D: Out-of-Network Cost to Members
- MED 1E: Hours of Operation Parity

Not all Medicaid plans are required to comply with these Medicaid requirements. NCQA does not assign accreditation points to this voluntary standard but will work with health plans and state Medicaid offices to report plan performance on the elements, if applicable.

²Equivalency refers to the percentage of federal regulations under 438.204(g) having a parallel NCQA Accreditation standard that meets the intent of the regulation. The percentage includes NCQA standards directly equivalent and those that meet the intent with some variation. Regulations that are not applicable to NCQA accreditation are excluded from the calculation. Maximum potential equivalency (100%) is state specific.

Center for Medicaid, CHIP and Survey & Certification and EQRO Reporting Requirements

States should follow up with Gary Jackson at the Center for Medicaid, CHIP and Survey & Certification (CMCSC)³ (gary.jackson@cms.hhs.gov) for precise steps to take in amending their quality strategies and communicating process changes to the EQRO.

³ Formerly known as the Center for Medicaid & State Operations (CMSO)

Implementing Deeming

Over the years, states have requested more detail as to what steps are needed to deem NCQA Accreditation standards. The sections below address how NCQA's Public Policy Department can assist state Medicaid agencies in this process.

Assistance from NCQA's Public Policy Department

NCQA's Public Policy Department partners with state agencies to align the state's quality strategy and operational standards with NCQA's requirements for performance improvement and measurement. The Public Policy Department is available as a resource to state agencies that have questions about NCQA's programs or that wish to learn more about the process of using accreditation for streamlined oversight.

State-specific Crosswalk

States have flexibility to build upon federal managed care oversight requirements. In light of this, NCQA recommends constructing a state-specific crosswalk which will identify those requirements that can be deemed. NCQA's Public Policy Department can work with your agency to develop a crosswalk and ensure accurate interpretation of the NCQA standards. See page 9 for examples of how states have used NCQA accreditation.

Timelines/Language

In states that mandate NCQA Accreditation, NCQA's Public Policy Department works with state Medicaid agencies to develop state-specific timelines for plans to achieve accreditation. Our goal is to ensure consistent communication between health plans, the state and NCQA. We can also advise on language for policy statements and contractual requirements.

Meetings and Trainings

The Public Policy Department frequently meets with state agencies to help them understand how NCQA's accreditation and performance measurement processes work. Depending on the type of information needed we can meet in person, via phone or Web-Ex.

General Questions

The Public Policy staff member assigned to work with your state agency will serve as a point of contact for any NCQA-related inquiries you may have. Our goal is to develop partnerships with state Medicaid programs to assist in quality improvement efforts.

Technical Assistance. Public Policy and NCQA's accreditation staff work together to answer technical questions from states. The Policy Clarification Support (PCS) system allows NCQA to manage technical questions and provide a coordinated and timely response. PCS - <http://web.ncqa.org/ContactUs.aspx>

NCQA Accreditation in State Medicaid Programs

Value of Accreditation

Measurement, Accountability & Transparency

The value of health care delivered by a managed care system cannot be demonstrated without the use of performance measures. We believe measurement drives accountability which leads to quality improvement. All accreditation results are made available to the public enabling state purchasers to make value-based contracting decisions and enabling patients to have quality information upon which to choose a plan (see NCQA Public Reporting below). Patients benefit from the added transparency in the managed care marketplace driven by NCQA Accreditation.

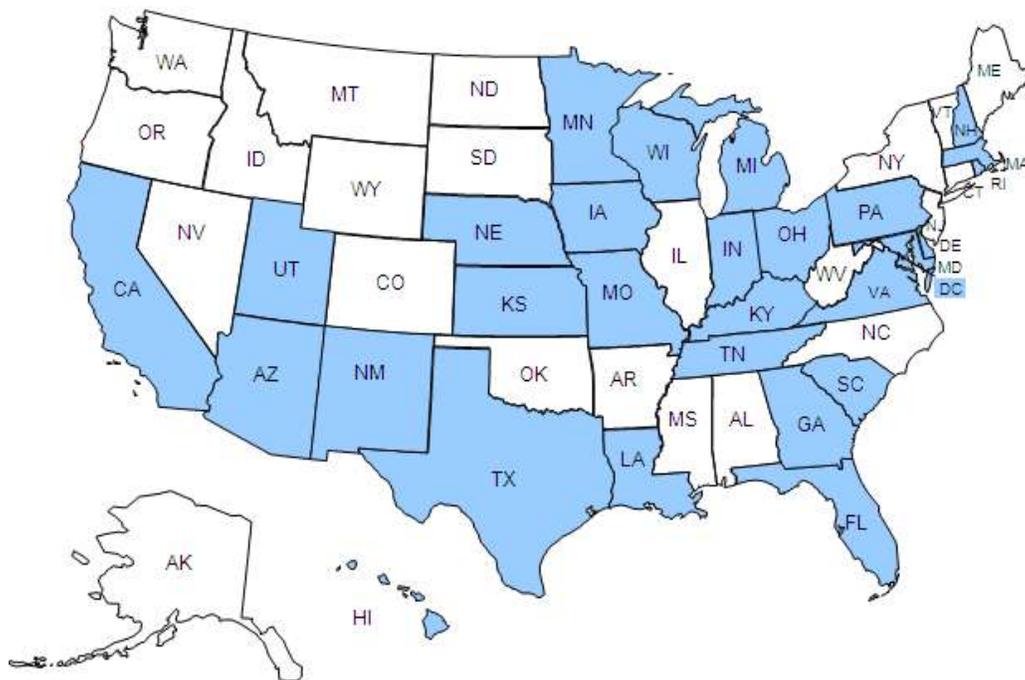
NCQA is the only accreditation organization to emphasize performance measurement through quantitative analysis of health outcomes among enrollees of health plans. NCQA's HEDIS performance measures allow for comparisons across organizations, agencies and states. NCQA's Health Plan Accreditation standards attribute 45.86% of a plan's accreditation score comes from HEDIS and CAHPS results.

In 2011, 118 million Americans were enrolled in health plans that use HEDIS to measure and report on the quality of care⁴.

State Use of Accreditation

As of February 2012, 41 states, including 29 Medicaid programs recognize or require NCQA Accreditation. There are many ways in which these state Medicaid programs have incorporated NCQA Accreditation into their quality oversight practices. Some examples are cited below. For the detailed list of state Medicaid recognition, see Appendix 2.

29 Medicaid Programs Use or Require NCQA Accreditation as of February 2012



⁴ NCQA State of Health Care Quality 2011

Requiring NCQA Accreditation

Tennessee's TennCare program requires NCQA Accreditation for Medicaid managed care plans. NCQA has worked closely with TennCare to assist them with implementing quality oversight that maximizes the use of accreditation.

Including Tennessee, 12 states require NCQA Accreditation for Medicaid health plans: District of Columbia, Indiana, Kansas, Kentucky, Massachusetts, Missouri, New Mexico, Rhode Island, Virginia and South Carolina.

Recognizing Accreditation

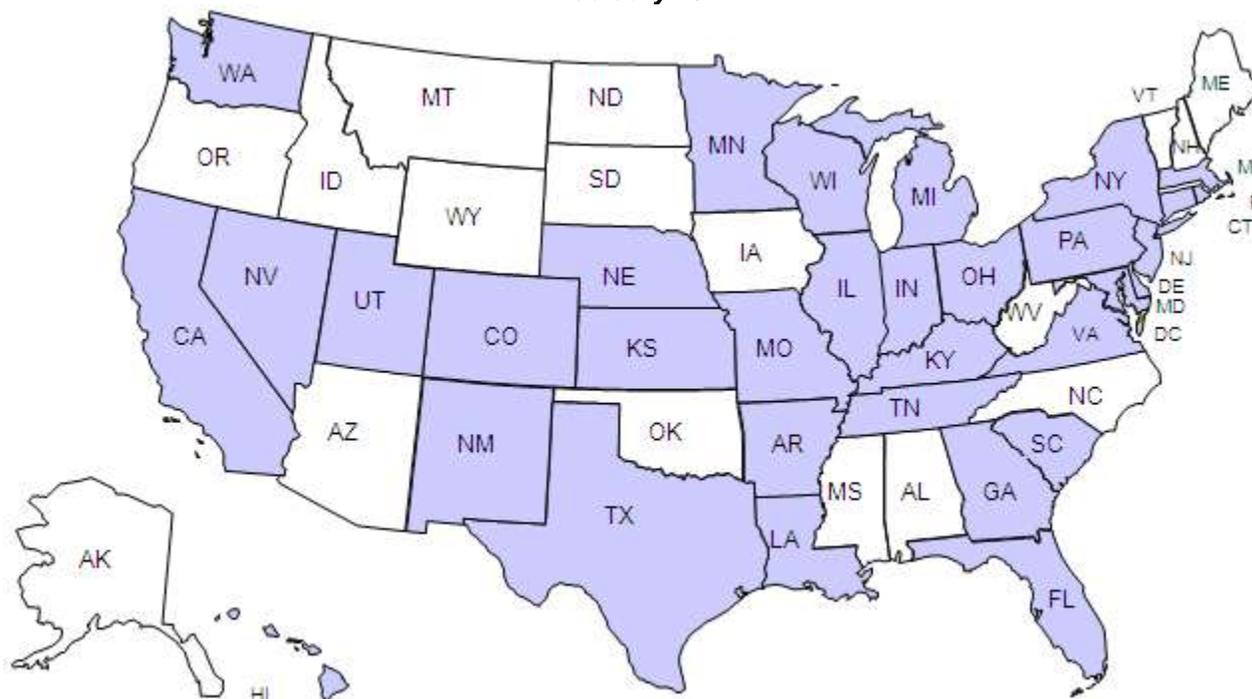
The Medicaid programs in 17 states use NCQA Accreditation to demonstrate compliance with components of the External Quality Review and state-specific requirements.

For example, in Michigan's Medicaid program, NCQA Accreditation is used to exempt plans from certain portions of the state's annual onsite review. NCQA Accreditation is also used in the state's consumer guide and annual bonus awards to the plans.

State Use of HEDIS

As of February 2012, 39 states including 34 Medicaid programs require reporting of the Health Care Effectiveness Data and Information Set (HEDIS). Collecting HEDIS data allows states to make apples to apples comparisons of plan quality and set high performance standards in managed care contracts. States, like Maryland, have also used HEDIS results to build consumer report cards that help state residents make more informed health insurance purchasing decisions.

34 Medicaid Programs Use HEDIS Measures or Require Audited HEDIS Reporting as of February 2012



Health Insurance Exchanges

Similar to the Medicaid child and adult core sets of measures (see below), NCQA is recommending to states and the federal government to rely on HEDIS measures for the Health Insurance Exchange quality reporting requirements. NCQA's Public Policy and Quality Solutions Group Staff are prepared to support states in their Exchange development efforts.

Other NCQA Medicaid-Related Initiatives

Core Sets of Quality Measures for Medicaid and CHIP

The Children's Health Insurance Program Reauthorization Act (2009) and the Patient Protection and Affordable Care Act (2010) directed CMS to develop two core sets of quality measures – one for children enrolled in CHIP and one for adults enrolled in Medicaid. States are asked to voluntarily report data to the federal government. Because of NCQA's rigorous development and testing process, HEDIS measures make up the majority of measures used in both sets. NCQA staff work closely with CMS and support state reporting efforts by providing technical assistance.

Patient-Centered Medical Home Recognition

The patient centered medical home is a model of care that holds significant promise for better health care quality, improved involvement of patients in their own care and reduced costs over time. The precepts of the medical home are articulated in the Joint Principles of the Medical Home developed by the primary care medical societies and are measured by NCQA's current [Physician Practice Connections®–Patient-Centered Medical Home \(PPC-PCMH™\) Recognition Program](#).

To maximize the efforts of practices seeking recognition, NCQA released an updated version of the Patient-Centered Medical Home (PCMH) standards in January of 2011.⁵ These new standards are strongly aligned with the Health IT Meaningful Use requirements promulgated under the American Recovery & Reinvestment Act (ARRA) subsection on Health Information Technology for Economic and Clinical Health Act (HITECH).

“Organizations such as the National Committee for Quality Assurance (NCQA)...could affect health IT adoption if they incorporated meaningful-use criteria into the various accreditation systems. The NCQA has already done so, in part, by incorporating electronic communication, electronic prescribing, and registry functions into the qualifying criteria for the patient-centered medical home.”

--David Blumenthal, National Coordinator for Health IT

Health Affairs, September 2010, p.1669

More than 30 states have been seeking to improve Medicaid and CHIP beneficiaries' access to high functioning medical homes⁶. This is not surprising given the growing body of evidence that suggests PCMH initiatives can improve quality and lower costs. A July 2011 article in *Health Affairs* identified 18 state-driven PCMH pilots, 12 of which used NCQA's program. It also highlighted important preliminary successes from the demonstrations such as lower emergency room utilization, improved access to care and patient satisfaction, higher adherence to evidence-based medicine, and lower per member costs.⁷

Health Homes

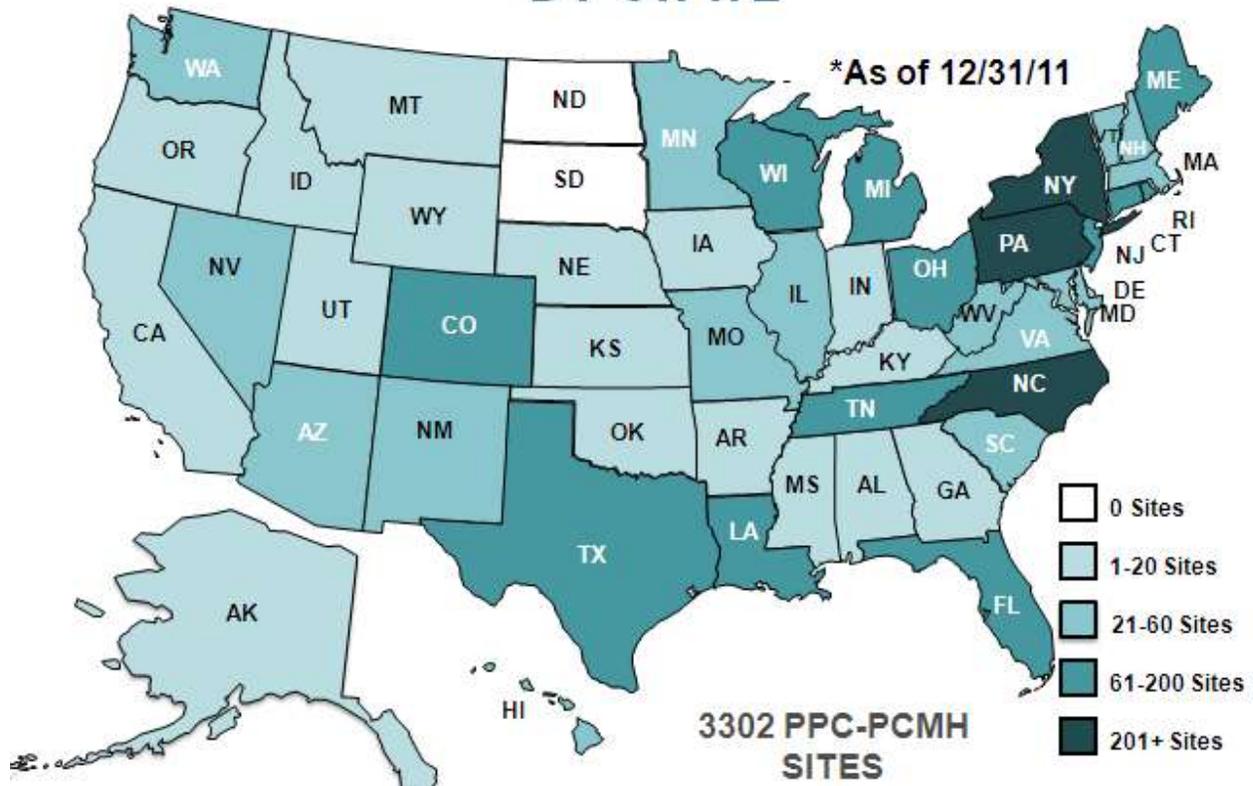
Under Section 2703 of the Affordable Care Act, states can receive an enhanced federal match (90%) for care delivered to chronically ill patients at designated "[health homes](#)." States have shown interest in using NCQA's program as part of 2703 projects because of its flexibility. NCQA's Public Policy and Product Development staff is available to support state health home efforts.

⁵ The 2011 PPC-PCMH™ Standards and Guidelines are available for free on [NCQA's Website](#).

⁶ National Association for State Health Policy: State Policy Briefing - State Multi-Payer Medical Home Initiatives and Medicare's Advanced Primary Care Demonstration. February 2010.

⁷ Takach, Mary. Reinventing Medicaid: State Innovations to Qualify and Pay For Patient-Centered Medical Homes Show Promising Results. *Health Affairs*, 30, no.7 (2011):1325-1334

NUMBER OF PPC-PCMH & PCMH SITES BY STATE



NCQA's Public Policy staff is available to discuss approaches for engaging contracted managed care organizations in measuring and rewarding the provision of patient centered primary care to members.

Accountable Care Organization Accreditation

NCQA released its standards and guidelines for Accountable Care Organization (ACO) Accreditation in November 2011. The program provides a roadmap for provider-led organizations to demonstrate their ability to reach the triple aim: reduce cost, improve quality and enhance the patient experience. The program builds on patient-centered medical homes and provides an independent evaluation of organizations' ability to coordinate the high-quality, efficient, patient-centered care expected of ACOs. NCQA worked with consumer advocates, purchasers and experts in the fields of health care delivery, health services research and managed care to develop a comprehensive set of standards to evaluate ACOs. NCQA ACO Accreditation includes two major components: standards, an evaluation of an ACO's structure and processes; and measures, an evaluation of an organization's capability to report performance results.

The program evaluates organizations in seven categories:

1. ACO Structure and Operations
2. Access to Needed Providers
3. Patient-Centered Primary Care
4. Care Management
5. Care Coordination and Transitions
6. Patient Rights and Responsibilities

The program aligns with many of the expectations that the Centers for Medicare & Medicaid Services (CMS) has for the Medicare Shared Savings Program, as well as with common expectations of private purchasers.⁸ A number of states are exploring the use of ACOs in their Medicaid programs (e.g. UT, CO, OR). <http://www.ncqa.org/tabid/1312/Default.aspx>

⁸ A crosswalk identifying how NCQA's program aligns with the final regulations for the Shared Savings Program is available upon request.

Additional NCQA Resources for States

Quality Solutions Group

As a contractual services arm of NCQA, the [Quality Solutions Group \(QSG\)](#) can provide customized services to meet the needs of states, in areas such as program development and management; performance measurement, benchmarking and reporting; data management and verification; training and technical support; and customized analysis and reporting.

NCQA has a HEDIS Data Collection Services (HDCS) that offers state agencies an efficient, cost-effective way to collect HEDIS performance measures from health plans. HDCS is backed by NCQA's years of nationwide HEDIS data collection experience. The benefits of HDCS to participating states are:

- Collection of data in an efficient and uniform manner
- Delivery of HEDIS data in analysis-ready files
- Use of the same data submission process and tools health plans are already using for NCQA in order to reduce compliance burden

In addition, NCQA works with states to develop plan rating systems and report cards help people make better informed health care decisions. NCQA develops each report taking into account the specific needs of the sponsors. We are experienced in testing report card prototypes to ensure the information is comprehensible and meaningful to the target audience. NCQA staff members have experience designing reporting formats, producing report content and conducting data analysis.

Other NCQA Programs

In addition to HPA and HEDIS performance measurement, NCQA's other accreditation and certification programs can provide valuable quality measures and standards for specific components of Medicaid programs. Those programs include the following:

- [Disease Management Accreditation and Certification](#)
- [Managed Behavioral Health Organization \(MBHO\) Accreditation](#)
- [Accountable Care Organization Accreditation](#)
- [Wellness and Health Promotion Accreditation and Certification](#)
- [Organizational Certification in Credentialing or Utilization Management](#)
- [Physician and Hospital Quality Certification](#)
- [Provider Recognition Programs](#):
 - [Diabetes Provider Recognition Program](#)
 - [Government Recognition Initiative](#)
 - [Heart and Stroke Recognition Program](#)
 - [Back Pain Recognition Program](#)
 - [Physician Practice Connections](#)
 - [Physician Practice Connections – Patient-Centered Medical Home](#)

NCQA Public Reporting

State of Health Care Quality Report *(in NCQA's Resource Library on the web)*

[The State of Health Care Quality](#) report is released annually in the fall and contains aggregate data with selected national HEDIS and CAHPS percentiles. It provides the national mean and 10th and 90th percentiles for the current year, as well as previous years' national averages for the selected measures. It is posted to NCQA's Web site and includes additional information related to resource use and quality.

Health Insurance Plan Rankings

[NCQA's Health Insurance Plan Rankings 2011-2012](#) are posted online and feature NCQA's rankings of the nation's Private, Medicare and Medicaid health insurance plans based on their combined HEDIS®, CAHPS® and NCQA Accreditation standards scores.

Consumer Reports published, with NCQA's permission, NCQA's Medicaid, Medicare and private plan rankings online in October and in the November issue of the magazine, ensuring that this valuable information reaches millions of Americans.

NCQA's Health Insurance Plan Rankings 2011-12 use NCQA's established rankings methodology, which has been used and widely recognized since 2005. Consumer Reports and NCQA have agreed to collaborate in 2012 to develop new ways to help consumers evaluate the quality of health insurance plans.

NCQA Health Plan Report Card

[NCQA's public scorecard](#) of accredited health plans includes results for MCOs and PPO plans. It provides summary level performance in five areas relevant to consumers: Access & Service, Qualified Providers, Staying Healthy, Getting Better and Living with Illness. *Updated monthly*

Quality Compass

[A national database](#) of commercial or Medicaid data produced annually, this product contains health plan-specific results as well as national and regional benchmarks and percentiles. It contains information for all reportable HEDIS measures⁹, including utilization measures from the Use of Services domain. Data are available for purchase in an online format. *Posted annually in late July*

⁹ First-year measures are not included in *Quality Compass*.

APPENDIX 1

ANNOTATED FEDERAL REGULATIONS

42 CFR §438.360—Non-duplication of mandatory activities

(a) **General rule** To avoid duplication, the State may use, in place of a Medicaid review by the State, its agent, or EQRO, information about the MCO or PIHP obtained from a Medicare or private accreditation review to provide information otherwise obtained from the mandatory activities specified in §438.358 if the conditions of paragraph (b) or paragraph (c) of this section are met.

(b) **MCOs or PIHPs reviewed by Medicare or private accrediting organizations** For information about an MCO's or PIHP's compliance with one or more standards required under §438.204(g)¹⁰ (**except** with respect to standards under §§438.240(b)(1)¹¹ and (2)¹² for the conduct of performance improvement projects and calculation of performance measures respectively)¹³ the following conditions must be met:

- (1) The MCO or PIHP is in compliance with standards established by CMS for Medicare+Choice or a national accrediting organization. The CMS or national accreditation standards are comparable to standards established by the State to comply with §438.204(g) and the EQR-related activity under §438.358(b)(3).
- (2) Compliance with the standards is determined either by—
 - (i) CMS or its contractor for Medicare; or
 - (ii) A private national accrediting organization that CMS has approved as applying standards at least as stringent as Medicare under the procedures in §422.158.
- (3) The MCO or PIHP provides to the State all the reports, findings, and other results of the Medicare or private accreditation review applicable to the standards provided for in §438.204(g); and the State provides the information to the EQRO.
- (4) In its quality strategy, the State identifies the standards for which the EQR will use information from Medicare or private accreditation reviews, and explains its rationale for why the standards are duplicative.

¹⁰ Same as 438.358 (b)(3)

¹¹ Same as 438.358 (b)(1)

¹² Same as 438.358 (b)(2)

¹³ The applicable NCQA Accreditation standards that qualify for exemption are included in the NCQA Medicaid Standards Crosswalk; PIP and Performance Measure activities are not part of the non-duplication regulation.

(c) **Additional provisions for MCOs or PIHPs serving only dually eligibles**¹⁴ The State may use information obtained from the Medicare program in place of information produced by the State, its agent, or EQRO with respect to the mandatory activities specified in §438.358 (b)(1) and (b)(2) if the following conditions are met:

- (1) The MCO or PIHP serves only individuals who receive both Medicare and Medicaid benefits.
- (2) The Medicare review activities are substantially comparable to the State-specified mandatory activities in §438.358(b)(1) and (b)(2).
- (3) The MCO or PIHP provides to the State all the reports, findings, and other results of the Medicare review from the activities specified under §438.358(b)(1) and (b)(2) and the State provides the information to the EQRO.
- (4) In its quality strategy, the State identifies the mandatory activities for which it has exercised this option and explains its rationale for why these activities are duplicative.¹⁵

.01 Source: As adopted, 68 FR 3586 (Jan. 24, 2003, effective Mar. 25, 2003).

42 CFR §438.358—Activities related to external quality review.

- (a) **General rule:** The State, its agent that is not an MCO or PIHP, or an EQRO may perform the mandatory and optional EQR-related activities in this section.
- (b) **Mandatory activities:** For each MCO and PIHP, the EQR must use information from the following activities:

(1) Validation of performance improvement projects required by the State to comply with requirements set forth in 438.240(b)(1) and that were underway during the preceding 12 months.¹

438.240(b)(1)²

(1) The State must require that each MCO and PIHP... conduct performance improvement projects³ as described in *paragraph (d)* of this section. These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.

Paragraph (d)

(1) MCOs and PIHPs must have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas⁴, and that involve the following:

- (i) Measurement of performance using objective quality indicators.
- (ii) Implementation of system interventions to achieve improvement in quality.
- (iii) Evaluation of the effectiveness of the interventions.
- (iv) Planning and initiation of activities for increasing or sustaining improvement.

¹⁴ Section (c) is only applicable for NCQA Accredited plans that are Medicare Accredited and whose only other product line is Medicaid.

¹⁵ See the NCQA Medicaid Standards Crosswalk for equivalency analysis with federal requirements.

(2) Each MCO and PIHP must report the status and results of each project to the State as requested, including those that incorporate the requirements of *Sec. 438.240(a)(2)*. Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

438.240(a)(2)

CMS, in consultation with States and other stakeholders, may specify performance measures and topics for performance improvement projects to be required by States in their contracts with MCOs and PIHPs.

¹ State can define PIPs to include HEDIS or QI standards.

² This section defines what the state requires from plans and consequently, what must be validated through the EQR process.

³ Improvements in a plan's HEDIS scores could only be an option for states that have PIPs and that use HEDIS/CAHPS measures to meet that requirement.

⁴ States can choose measures from HEDIS/CAHPS to meet the intent of paragraph D.

2) Validation of MCO or PIHP performance measures reported (as required by the State) or MCO or PIHP performance measure calculated by the State during the preceding 12 months to comply with requirements set forth in §438.240(b)(2).⁵

438.240(b)(2)

The State must require each MCO and PIHP to...submit performance measurement data as described in paragraph (c) of this section.

Paragraph C

Annually each MCO and PIHP must—

(1) Measure and report to the State its performance, using standard measures required by the State including those that incorporate the requirements of Sec. 438.204(c) and Sec. 438.240(a)(2);

438.204(c)

For MCOs and PIHPs, any national performance measures and levels that may be identified and developed by CMS in consultation with States and other relevant stakeholders.

438.240(a)(2)

CMS, in consultation with States and other stakeholders, may specify performance measures and topics for performance improvement projects to be required by States in their contracts with MCOs and PIHPs.

(2) Submit to the State, data specified by the State, that enables the State to measure the MCO's or PIHP's performance; or

(3) Perform a combination of the activities described in paragraphs (c)(1) and (c)(2) of this section.

(3) A review, conducted within the previous 3-year period, to determine the MCO's or PIHP's compliance with standards established by the State to comply with the requirements of §438.204(g).⁶

§438.204⁷

At a minimum, State strategies must include the following: (g) Standards, at least as stringent as those in the following sections of this subpart, for

- access to care (438.206, 207,208,210)
- structure and operations (438.214, 218, 224, 226, 228, 230)
- quality measurement and improvement (438.236, 240, 242)⁸

⁵ Validation may be done via a HEDIS Compliance Audit™; a non-HEDIS Compliance Audit validation would not meet NCQA HEDIS reporting requirements. States can require plans to report HEDIS (or other measures); however, a HEDIS Compliance Audit (i.e., performance measure validation) may not be controlled by the plans in order for the validation to be independent and therefore meet the qualification for enhanced Federal Medicaid funding. An alternative would be for the state to pay for the compliance audit on behalf of the plans.

⁶ This is the “deemable” area of operational standards for plans. The state may exempt plans from all or part of this element of EQR if the plan is accredited.

⁷ This section defines what the state requires from plans at a minimum, and consequently, what must be validated through the EQR process.

⁸ NCQA's Accreditation program can meet the intent of the federal requirements in many cases.

APPENDIX 2

STATES RECOGNIZING NCQA ACCREDITATION FOR MEDICAID

1. **Arizona:** The Arizona Health Care Cost Containment System recognizes providers credentialed by NCQA Accredited health plans as meeting state credentialing requirements (AHCCCS Medical Policy Manual, Chapter 900; <http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap900.pdf>).
2. **California:** NCQA Accreditation is deemed for meeting state credentialing requirements. Non-accredited plans contracting with NCQA certified physician organizations are also deemed compliant with state requirements. (MMCD Policy Letter 02-03)
3. **Delaware:** The state recognizes NCQA Accreditation as meeting access to care, structure and operations, and quality and improvement standards (State Regulation: 14 De. 650)
4. ***District of Columbia:** DC's Medical Assistance Administration requires contracted managed care plans to hold NCQA Accreditation.
5. **Florida:** All managed care plans must be accredited by NCQA or another nationally recognized accrediting body. (HB7107 – Passed 6/02/2011).
6. **Georgia:** Medicaid managed care plans are required to obtain private accreditation by 2009. Georgia Department of Community Health.
7. **Hawaii:** Accreditation is required for all health plans (State Law: 432E-11).
8. ***Indiana:** Managed care organizations and managed behavioral health organizations in the Medicaid program must be NCQA Accredited by January 1, 2011 (IC 12-15-12).
9. **Iowa:** The Human Services Department accepts NCQA Accreditation for the state's accreditation requirement for Medicaid managed care plans. (State Regulation: 441-88.2).
10. ***Kansas:** (New!) Per KanCare contracts and the State Quality Strategy, Medicaid contractors and subcontractor(s) are required to become accredited by the National Committee for Quality Assurance (NCQA) as defined by the State.
11. ***Kentucky:** Kentucky's Cabinet for Health and Family Services requires managed care plans to be NCQA Accredited as a condition of doing business.
12. **Louisiana:** Accreditation is required for the full-risk Medicaid managed care plans per state contracting requirements. (LAC 50:I.3501).
13. **Maryland:** Health plans may submit accreditation reports to demonstrate compliance with state requirements. (State Law: 19-705.1).
14. ***Massachusetts:** MassHealth plans must be NCQA accredited within two years of the start of their (July 2010) contract. MCOs can use evidence of NCQA accreditation to show compliance with several components of the EQRO review.
15. **Michigan:** Per state contract requirements, Medicaid managed care plans must be accredited. (Section 1.022-K)
16. **Minnesota:** Minnesota Department of Human Services recognizes many NCQA accreditation standards under CFR 438.360. Specific standard categories that are recognized are under quality improvement, utilization management, credentialing and member rights and responsibilities.
17. ***Missouri:** Missouri's Managed Care health plans are required to obtain health plan accreditation, at a level of "accredited" or better, from NCQA within twenty-four (24) months of the first day of the effective date of the contract. The health plans are required to maintain such accreditation thereafter and throughout the duration of the contract.
18. **Nebraska:** MCOs must have NCQA Accreditation or another national accreditation for the Medicaid Managed Care plan. MCOs must submit a copy of the accrediting body's letter indicating the most recent

accreditation status at the time of initial contracting. Any changes or updates must be sent to DHHS within 30 days of receipt. (State Regulation: 482 NAC 6-000)

19. **New Hampshire:** Managed care plans may delegate credentialing activities only if such delegated credentialing is maintained in accordance with the National Committee for Quality Assurance (NCQA) delegated credentialing requirements and any comparable requirements defined by DHHS.

20. ***New Mexico:** NCQA accreditation is required for Medicaid managed care plans. (State Regulation: 8.305.8.11).

21. ***Ohio:** Managed care plans must hold and maintain, or must be actively seeking accreditation by NCQA. A managed care plan not currently NCQA accredited must submit a signed copy of the NCQA Survey Contract to ODJFS by July 1, 2012 and complete the accreditation process by June 30, 2013. (MCP Contract, Appendix C: MCP Responsibilities - 45)

22. **Pennsylvania:** NCQA accreditation reports are used as part of the state's routine monitoring of Medicaid managed care plans. Pennsylvania Department of Public Welfare.

23. ***Rhode Island:** Per state contracting requirements, Medicaid managed care plans must be accredited by NCQA (sec. 2.02 Licensure).

24. ***South Carolina:** Accreditation is required for Medicaid managed care plans. South Carolina Department of Health and Human Services.

25. **Texas:** The Texas Department of Insurance mandates the use of NCQA's credentialing standards by all health care plans in the state. Plans must follow the most current version of NCQA's credentialing requirements from year to year.

26. ***Tennessee:** All plans contracting with TennCare (Medicaid) must be NCQA Accredited.

27. **Utah:** NCQA Accreditation meets some of Utah's contractual requirements for Medicaid plans. Utah Department of Health.

28. ***Virginia:** Medicaid managed care plans are required to maintain NCQA Accreditation.

29. **Wisconsin:** The Wisconsin Medicaid HMO Accreditation Incentive allows health plans to submit evidence of accreditation in lieu of providing documentation for performance improvement projects and undergoing onsite external quality reviews.

APPENDIX 3

STATES REQUIRING THE USE OF HEDIS FOR MEDICAID

1. **Arkansas:** Arkansas uses HEDIS measures to monitor the quality of care provided to beneficiaries in both ARKids First A and ARKids First B programs.
2. **California:** The California Department of Health requires its contracted Medicaid managed care plans to submit audited HEDIS and CAHPS data. Managed Risk Medical Insurance Board (MRMIB) required its SCHIP contracted plans to submit HEDIS and CAHPS data. www.dhs.ca.gov/mcs/Reports/Reports.htm.
3. **Colorado:** Health Care Cooperatives must submit disenrollment HEDIS measures. State Regulation: 10 CCR 2505-2 Rule IX.
4. **Connecticut:** As of 1/1/12 Administrative Service Organization contractor(s) will be required to submit audited HEDIS data to the state. State ASO RFP N.12.2
5. **Delaware:** Medicaid managed care plans are required to submit HEDIS performance measures (State Regulation 14 De. 650).
6. **District of Columbia:** Per contract, Medicaid managed care plans are required to submit audited HEDIS measures to the District.
7. **Florida:** Contracted MCOs must collect and report HEDIS measures, as specified by AHCA. These measures must be published on the plan's website in a manner that allows recipients to reliably compare the performance of plans. The agency shall use the HEDIS measures as a tool to monitor plan performance. (HB7017)
8. **Georgia:** Per state contract requirements (Section 4.12.3) for the Georgia Families program, plans must report HEDIS data to the state.
9. **Hawaii:** Per contracts for QUEST, plans are required to submit HEDIS and CAHPS data to the state (Section 51.620).
10. **Illinois:** Managed care contractors for the Integrated Care Program and voluntary managed care program are required to report audited HEDIS and CAHPS data to the state.
11. **Indiana:** Plans must be NCQA accredited which requires submission of audited HEDIS data.
12. **Kansas:** (New!) KanCare plans must be NCQA accredited which requires submission of audited HEDIS data.
13. **Kentucky:** Plans are required to maintain NCQA accreditation and report audited HEDIS data.
14. **Louisiana:** Per state contracts for Coordinated Care Networks (CCN-P / CCN-S), managed care plans are required to report HEDIS measures to the state.
15. **Maryland:** Medicaid HMOs are required to annually report HEDIS data to the state. COMAR 10.09.65.15, 10.09.65.03.
16. **Massachusetts:** Medicaid HMOs must be NCQA accredited which required audited HEDIS reporting.
17. **Michigan:** Per state contract requirements, Medicaid managed care plans must report audited HEDIS data to the state annually (Section 1.042-A4).
18. **Minnesota:** Medicaid HMOs are required to report audited HEDIS data to the state.
19. **Missouri:** Medicaid HMOs are required to report audited HEDIS data to the state. State Law: 192.068.
20. **Nebraska:** For Medicaid managed care, the most recent HEDIS encounter data will be reported by the HMO and MH/SA plans. State Regulation: 482 NAC 6-006.
21. **Nevada:** Medicaid HMOs shall produce reports using HEDIS, as specified in Section 2.6.1 of the DHCFP Managed Care Contract.

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22. **New Jersey:** Per state contracts, Medicaid managed care plans must submit HEDIS data annually to the state. (Section 4.6.2-7)
23. **New Mexico:** All Medicaid HMOs are required to submit audited HEDIS data to the state. State Regulation: 8.305.8.11 NMAC.
24. **New York:** Annual reporting of New York's Quality Assurance Reporting Requirements (QARR) is required of Medicaid managed care plans. Many Medicaid HEDIS measures are included in QARR. New York State's Operational Protocol for The Partnership Plan.
25. **Ohio:** Per MCO contract requirements, plans are required to report audited HEDIS measures and additional HEDIS-like measures to the state.
26. **Pennsylvania:** Audited HEDIS reporting is required for Medicaid managed care plans. <http://www.dpw.state.pa.us/omap/hcmc/hcagr/pdf/HCStandAgreeExhibitM4.pdf>.
27. **Rhode Island:** Per state contract requirements, Medicaid managed care plans must be NCQA-accredited, which includes submitting audited HEDIS data. Medicaid Managed Care Services Contract (effective 9/1/2010).
28. **South Carolina:** Plans must be NCQA accredited which requires submission of audited HEDIS data.
29. **Tennessee:** TennCare plans are required to report HEDIS in conjunction with an NCQA accreditation requirement. Bureau of TennCare.
30. **Texas:** Medicaid managed care contracts require organizations to develop a monitoring program for measuring the quality of the health care services provided by the organization's provider network that incorporates the NCQA's HEDIS measures (Section 533.005 – Amended 7/2011 by S.B.7).
31. **Utah:** Medicaid and CHIP managed care plans are required to report HEDIS measures.
32. **Virginia:** Select measures required for Medallion II plans. Additional measures encouraged for demonstration of quality improvement.
33. **Washington:** Washington Health Care Authority requires production of many of the HEDIS measures to meet state performance measure reporting requirements for plans serving Medicaid and SCHIP.
34. **Wisconsin:** Per state contract requirements, all plans are required to report HEDIS data for use in a pay-for-performance program.

APPENDIX 4

GLOSSARY OF TERMS

Crosswalk Tabs

Deemable regulations	Access to Care, Structure and Operations and Quality Measurement and Improvement regulations under 42 CFR 438.204(g). Per 42 CFR 438.360, in place of a Medicaid review by the state, its agent or EQRO, states can use information obtained from a national accrediting organization review for the determining plan compliance with standards established by the state to comply with these requirements.
Quality strategy	These regulations specify the required components of a state's quality strategy. The NCQA standard or measure demonstrates where NCQA information can be used by state as part of their quality oversight.
Information requirements	These regulations are referenced but are not cited in the deemable regulations under 42 CFR 438.204(g).
Grievances	These regulations are referenced but are not cited in the deemable regulations under 42 CFR 438.204(g).

Equivalency Column

Met	The NCQA standard meets the requirements under the federal regulation. A plan that meets the NCQA standard would meet the federal requirement.
Almost Met	The NCQA standard is very close to meeting the federal requirement. Components of the corresponding state requirement require some additional review if the plan met the NCQA standard.
Partially Met	The NCQA standard could meet the state requirement. The state requirement would need to be compared to the NCQA standard to determine the level of equivalency.
Not Met	NCQA does not have a standard that is similar to the federal requirement.
Not Applicable (NA)	The federal regulation is a requirement that the state has to report to the federal government rather than a requirement a plan must meet to demonstrate compliance.

Use Column

Deemable regulation	Access to Care, Structure and Operations and Quality Measurement and Improvement regulations under 42 CFR 438.204(g). Per 42 CFR 438.360, in place of a Medicaid review by the state, its agent or EQRO, states can use information obtained from a national accrediting organization review for determining plan compliance with standards established by the state to comply with these requirements.
Quality strategy	A state can use the comparable NCQA standards in their quality oversight of plans.
Comparison to state requirements	The NCQA standards would need to be compared to the comparable state requirement. These are not deemable regulations, but can be used by the state to streamline oversight.

APPENDIX 5

IMPORTANT NOTES

NCQA developed the NCQA Medicaid Managed Care Toolkit and the NCQA Medicaid Standards Crosswalk to provide guidance to states using NCQA products and services to support oversight and quality improvement efforts in their Medicaid programs. The crosswalk is an information source only. States will need to compare their regulatory or contractual requirements to NCQA's standards and measures to determine where they can streamline oversight or deem standards.

The 2012 Crosswalk includes NCQA's 2012 Health Plan Accreditation Standards, which are valid for accreditation surveys taking place between July 1, 2012 and June 30, 2013. For accreditation surveys taking place between July 1, 2011 and June 30, 2012, please refer to the 2011 Medicaid Managed Care Toolkit and Crosswalk and NCQA's 2011 Health Plan Accreditation Standards and Guidelines. NCQA's Public Policy Department is available to help states develop a comparison of their requirements to NCQA standards from the applicable standards year.

Each year, NCQA will release an annual update of the Toolkit to align with the annual update of NCQA's accreditation standards, which are released in July. This gives states and plans the opportunity to evaluate the information in advance of the time when plans are evaluated against those standards. NCQA also provides complimentary copies of the current HPA standards and/or HEDIS specifications to states that recognize or mandate NCQA's evaluation programs.

NCQA requests review of the Toolkit each year from the CMS Center for Medicaid, CHIP and Survey & Certification to ensure an accurate representation of the NCQA standards relative to the federal requirements included in the crosswalk.