Health Plan Accreditation 2015 and Additional Accreditation and Certification Product Updates

Overview
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**Our Mission: Improve the Quality of Health Care**

NCQA is dedicated to improving health care quality.

For almost 25 years, NCQA has been driving improvement throughout the health care system, helping to advance the issue of health care quality to the top of the national agenda. NCQA’s programs and services reflect a straightforward formula for improvement: measurement, transparency, accountability.

This approach works, as evidenced by the dramatic improvements in clinical quality demonstrated by NCQA-Accredited health plans—health maintenance organizations (HMO), point-of-service (POS) organizations, preferred provider organizations (PPO)—using both standards and performance results. Today, 136 million Americans (43%) are enrolled in a plan that collects and reports HEDIS data to NCQA.¹

**Background and Objectives**

NCQA’s environmental analysis revealed that the health care landscape is continuing to shift toward a focus on value and accountability. Public and private purchasers are looking for strategies to cut costs. Providers are increasingly pressured to deliver better value for health care dollars spent. Health plans are implementing a myriad of strategies to encourage behavior change in providers and patients (e.g., bundled payments, tiered networks).

The objective of the updates to Health Plan Accreditation 2015 is to align the program with current market needs and to meet current stakeholder needs by:

- Updating HEDIS/CAHPS scoring, to allow incorporation of measures that reflect value or cost.
- Updating the set of HEDIS/CAHPS measures for scoring.
- Including new standards that address two strategies that increase the delivery of value-based care: narrow/tiered networks (including those referred to as tailored and high performance) and transparency.

**Program Development to Date**

The proposed recommendations and standards reflect industry trends. NCQA staff conducted extensive literature reviews and obtained input from the Standards Committee and informational interviews with key stakeholders (e.g., health plans, consumer representatives, employer representatives).

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Summary of Proposed Changes

HPA HEDIS/CAHPS Measurement Strategy

Since 1999, NCQA Accreditation has scored health plans on the set of HEDIS/CAHPS measures that were in effect during the original standards year of their Accreditation Surveys. This approach has two limitations:

- Organizations are not rescoring annually on the same set of measures (by product line) during the three year-accreditation cycle. This limits, albeit only slightly, consistent comparison of performance across health plans.
  - For example, two measures were added in HPA 2013. Only health plans undergoing survey on or after July 1, 2013, report on these new measures; the remaining health plans with existing accreditation will not be scored on these measures until their Renewal Survey.
- Organizations tend to focus improvement efforts on measures being scored for accreditation. It may take several years for new measures to be included for scoring across all plans. This lag slows the spread of improvement initiatives focused on new measures, such as those related to value.

Scoring Update Recommendation

To create a more meaningful mix of measures and eliminate the limitations imposed by our current policies, NCQA recommends the following updates for HPA 2015:

1. Scoring update: Score all plans on the same set of HEDIS measures and methodologies for annual rescoring.
2. HEDIS/CAHPS update: Retire some HEDIS/CAHPS measures and replace them with measures from the current HEDIS/CAHPS measure suite.

The new scoring policy will be effective for all health plans undergoing survey under HPA 2015. This change will not be retroactive to health plans that are currently accredited. We project that by the annual rescoring process in 2018, all health plans will be subject to the same scoring rules and will be reporting on the same set of measures. We anticipate maintaining the current development and testing process for new performance measures such that a measure will not be eligible for inclusion in accreditation scoring until it has been approved for public reporting by the Committee on Performance Measurement.

Using the same measures for annual rescoring will provide greater consistency and comparability among health plans’ accreditation status and will:

- Improve NCQA’s ability to measure performance of all plans against a common set of measures more rapidly.
- Allow greater flexibility for updating measures in HPA in the future.

The change in scoring policy may affect the accreditation status of accredited health plans when new measures are added, and there may be financial implications for organizations that have performance guarantees included in contracts with purchasers.

NCQA seeks feedback on potential policies for easing the transition (e.g., minimum timeframe for notifying plans of measure and methodology changes, continued adherence to our ‘first year’ measure policy where a measure is not eligible for inclusion in scoring when it is first released).
Questions for Consideration

1. Do you support the proposal to score all plans using the same measures and methodology annually? If not, why not?
2. Given the proposed change to score all health plans on the same set of measures, what policies should NCQA put in place for updating the list of measures in Health Plan Accreditation?

HEDIS/CAHPS Measures Update Recommendation

There are many process measures scored in HPA. Although process measures are an important component of improving the quality of care, they do not tell us about the outcome of a treatment or episode of care (e.g., mortality or full recovery) and they do not address cost or efficiency of care.

NCQA proposes to retire some measures and add a mix of measures that more effectively evaluate and differentiate health plan performance.

Measure Selection Process

To select the measures proposed for scoring in HPA 2015, NCQA used the following methodology:

1. Compiled all HEDIS and CAHPS measures that are currently approved for public reporting.
2. Considered the HEDIS and CAHPS measures required in other national programs (e.g., Medicare STARS, Medicaid Child Core Set, proposed measures for the Exchange Quality Rating System).
3. Removed measures for which the guidelines are changing and for which there is a stronger measure alternative.
4. Identified and excluded measures for which health plans’ performance was topped out (i.e., the majority of health plans score high).
5. Identified and excluded measures that were highly correlated.
6. Selected measures based on the following guiding principles: proximity to outcomes, value (cost and quality), needs of vulnerable populations, national priority and parsimony.

Measures Proposed for Retirement From HPA

NCQA proposes retiring several HEDIS measures from HPA for the following reasons:

- Changes in guidelines (e.g., *Cholesterol Management for Patients With Cardiovascular Conditions*).
- Availability of a targeted measure that raises the bar on performance (e.g., *Use of Appropriate Medications for People With Asthma vs. Asthma Medication Management*).

NCQA also proposes to retire the CAHPS composite *How Well Doctors Communicate* because of little or no variation in performance among organizations on this measure.

Measures Proposed for Inclusion in HPA

Consistent with previous HPA updates, NCQA recommends including a number of additional measures from the existing HEDIS measure suite for each product line. At least two years of reporting has been completed for all recommended measures.
Because a number of measures have been recommended for retirement from HPA scoring, the overall number of measures that organizations would report for HPA 2015 would remain approximately the same for each product line (Table 1).

Table 1. Summary Count of HEDIS Measure Updates for HPA 2015

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Questions for Consideration

Consider the following questions for each product line separately.

1. Should NCQA retire all measures proposed for retirement from HPA?
   *If no*, which measures should be retained, and why? (Provide comments for all that apply.)

2. Should NCQA include all new measures proposed for scoring in HPA 2015?
   *If no*, which measures should be excluded, and why? (Provide comments for all that apply.)

3. Are there existing measures being scored that you would recommend for retirement?
   *If yes*, which measures should be retired, and why? (Provide comments for all that apply.)

4. NCQA anticipates including the All-Plan Cause Readmission measure and Relative Resource Use measures in HPA 2016. Do you support the inclusion of these measures? If not, why?

Refer to Appendix 1: List of Proposed Measures for Health Plan Accreditation 2015.
Network Monitoring Requirements

Health plans increasingly offer narrow and tiered network products (including those referred to as “tailored” and “high-performance” networks) as a means to lower costs and promote high quality providers. Between 2007 and 2013, the percentage of employers offering these networks as part of employee benefits packages increased from 15 percent to 23 percent. Early evidence indicates that health plans are limiting the practitioners and providers available to individuals enrolled in exchange plans; approximately half the exchange plans in 13 states will be composed of narrow networks. Surveys suggest that many exchange shoppers are willing to choose these options in order to obtain lower costs. However, others have been surprised to learn that their providers are not included in their initial plan selection, and as a result some insurers are allowing them to switch to broader network options.

When thoughtfully constructed, these networks have potential to reduce premiums and improve quality by providing access to the most effective and efficient providers. However, there is growing concern among some stakeholders about access to providers and the quality of care in these network designs. While there is no evidence so far of serious problems, as networks become narrower, they worry that individual providers (especially specialists) may have higher patient volumes and longer wait times for appointments. And, although some plans form these networks using both quality and cost, some consider only cost.

NCQA’s standards for access and availability (QI 4: Availability of Practitioners and QI 5: Accessibility of Services) are cited by many stakeholders (e.g., states, National Association of Insurance Commissioners [NAIC], AHIP) as sufficient to meet state and federal adequacy requirements and to ensure patient access. HEDIS and CAHPS measures are widely accepted as measures of network quality and member experience. However, access standards and quality/experience measures are evaluated at the product line/product level. As such, the performance of narrow networks is not as transparent as that of the overall network.

NCQA recognizes that entities such as the Centers for Medicare & Medicaid Services and NAIC are reevaluating existing network adequacy requirements and developing new approaches to capture access and quality in narrow networks. Despite the rapidly changing health care environment, NCQA feels it is necessary to introduce a standardized method of monitoring the quality of these networks. To meet immediate stakeholder needs, we propose adding two requirements related to narrow networks in Health Plan Accreditation 2015:

1. **Narrow, Tailored, Tiered and High-Value Network Monitoring (QI 6X):** Would require health plans to monitor member experience and the quality of practitioners and hospitals in these networks.

2. **Rights and Responsibilities Statement (RR 1A), factor 10:** Would require health plans to be transparent about policies for obtaining coverage for services accessed out of network.

We will monitor market developments and federal requirements as they emerge and will look for opportunities to align in the future.

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Narrow Tailored, Tiered and High-Value Network Monitoring (QI 6X)

NCQA recommends that for any narrow network (defined as a network that has 80% or less overlap with the broadest network in the product/product line coming forward for accreditation), tailored network, tiered-network or high-value network, organizations annually monitor:

- Member experience.
- Practitioner quality.
- Hospital quality.

Organizations will be required to analyze and compare results in these three areas with the performance of their broadest network. NCQA believes that this approach is more flexible and preferable to setting specific time and distance standards, which may be less meaningful for extremely narrow networks or for networks designed around specific conditions (e.g., Centers of Excellence). The recommendation is also in line with research findings indicating that member experience is a good indicator of the quality and adequacy of a health plan’s network.  

NCQA considered requiring separate HEDIS/CAHPS reporting for narrow networks, but determined that it would be a burden for plans to collect and submit measures for each narrow network, especially for hybrid and survey measures.

NCQA considered adding standards requiring plans to demonstrate that they consider cost and quality in constructing narrow networks (i.e., Physician and Hospital Quality Certification), but determined that the scope of review required exceeded what could reasonably be completed during an Accreditation Survey. Additionally, there may be business reasons for constructing a network that does not align with the Physician and Hospital Quality Certification (PHQ) requirements.

As part of the proposed requirement, health plans would provide information to purchasers, upon request, about the performance of their narrow networks.

Interviews with stakeholders (employer representatives, in particular) indicated that many employers are interested in offering narrow network benefit designs but are concerned about employee backlash. Information about the performance of these networks may help employers make informed decisions about these products. The availability of this type of information may also help with employee communication and outreach, which in turn could aid proliferation of value-based insurance designs (if the narrow networks demonstrate good performance). Additionally, requiring transparency about performance of these networks may offer an incentive to health plans to improve the performance of these products.

**Exchange Product Line**

Many concerns expressed by stakeholders are related to narrow networks offered in the state and federal marketplace (i.e., exchanges). NCQA believes that the current evaluation expectations for exchanges and the proposed requirement for HPA 2015 will address these concerns. Additionally, exchange plans are required to report HEDIS/CAHPS measures, beginning in 2016.

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Questions for Consideration

1. Do you support adding this element? If not, why not?
2. Should NCQA require health plans to monitor member experience for their narrow networks?
3. Should plans be required to track member appeals or complaints related to accessing out-of-network practitioners and providers for covered services when a practitioner is not available in-network?
4. Should NCQA require health plans to monitor the clinical performance of practitioners for their narrow networks?
5. Should NCQA require health plans to monitor the clinical performance of hospitals in their narrow networks?
6. Should NCQA require health plans to compare the performance of their narrow networks to that of their broadest network?
7. Should NCQA use “80 percent or less overlap with its broadest network” as the threshold that qualifies a network as narrow? If not, what is a reasonable threshold?
8. Should we limit this requirement to only those networks with a minimum number of enrolled members?
9. Should NCQA require health plans to provide information to purchasers about the criteria used to develop their narrow networks?
10. Should NCQA require that plans apply care coordination requirements to narrow networks; specifically, require them to provide continued coverage to new members who are on active treatment with an out of network provider?

Member Rights and Responsibilities Statement (RR 1, Element A)

NCQA proposes adding a factor requiring organizations to be transparent about whether members may access out-of-network providers for covered services, if those services are not available in-network. The member rights and responsibility statement specifies that members can access out-of-network practitioners, at the in-network benefit level, if the plan’s network does not have an appropriate practitioner or provider.

Some stakeholders indicated that this is standard practice for health plans and that many states require plans to provide coverage in this case. However, we did not find sufficient evidence in our research or interviews with stakeholders that these policies were consistent across plans or product lines.

Requiring “transparency” about the existence of these policies would simultaneously address consumer-advocate concerns about coverage, inform health plan members who may be unaware of existing policies and highlight opportunities for benefit plans where this provision does not exist.

Questions for Consideration

1. Do you support adding this element? If not, what is a reasonable requirement regarding access to out-of-network practitioners and providers when an appropriate practitioner/provider is not available in-network for covered services?

Refer to Appendix 2: Health Plan Accreditation 2015 Updates for the draft standard language.
Health Plan Accreditation 2015—Overview

Quality Transparency Standard: Practitioner and Hospital Quality Data (MEM X)

2013 was a pivotal year for health care transparency. Steven Brill’s article in Time Magazine, “The Bitter Pill: Why Medical Bills Are Killing Us,” spurred a nationwide conversation. The Senate Finance Committee held hearings about why health care costs account for more than 17 percent ($2.8 trillion) of the GDP, and there was ongoing media coverage about the exorbitant cost of care (e.g., “the $500 hospital stitch”). The result was widespread public awareness about how lack of transparency hurts consumers.

By the end of 2013, a number of sources predicted that transparency would be one of the top trends in 2014. But unlike other markets for goods and services, information about cost and quality is lacking for health care services. Available data show inexplicable variation in cost and quality of care for the same type of service delivered in the same geographic area.\(^9\),\(^10\),\(^11\)

Industry experts and researchers agree that making cost and quality data transparent is necessary to lower prices and increase quality. NCQA’s initial conversations with stakeholders revealed that although it may be desirable for health plans to provide members with comparable cost and quality information, it may not be feasible, because: 1) much of the quality data needed are largely unavailable; 2) providing cost data in the absence of quality data may give members an incentive to seek higher-priced services; and 3) market forces would be a more effective mechanism to drive the availability of cost information for consumers.

As an initial step toward transparency, NCQA proposes requiring plans to provide members with information on practitioner and hospital quality.

Practitioner Quality

NCQA recommends requiring health plans to provide their members with information on primary care physician, high-volume specialist and hospital quality. Health plans would be required to use valid and reliable methods to produce measures (e.g., HEDIS, NQF endorsed measures) and provide members with a description of the measures using clear, understandable language. Recent survey data indicate that consumers are looking at quality ratings when they seek health care services.\(^12\) Making this information available to members would incentivize its use when they select care providers.

Organizations that have achieved NCQA Physician Quality (PQ) Certification would be eligible for automatic credit.

Hospital Quality

Health plans would be required to provide members with information about hospital quality (e.g., hospital safety scores, readmission rates) from recognized sources (e.g., Medicare Hospital Compare).

Hospital quality data are readily available and can help members make informed decisions about where to seek care. Publishing hospital performance may encourage hospitals to improve performance.

Questions for Consideration

1. Do you support adding this element? If not, why not?
2. Should this element be applied to the Medicaid product line?
3. Do you agree that market forces will be a more effective mechanism to impact the availability of cost information for consumers?

Refer to Appendix 2: Health Plan Accreditation 2015 Updates for draft standard language.

Documents

Draft changes to HPA 2015 are explained in detail in the following documents.

- Appendix 2: Health Plan Accreditation 2015 Updates.
NCQA recommends the following changes to the 2015 health plan accreditation standards and guidelines and derivative products. These updates will align expectations with industry changes, reflect element intent and streamline content:

- **UM 1**: Align the element stem and scoring with the intent and remove the partial credit in the current scoring guidelines:
  - Element B: Clarify that a senior-level physician must be actively involved.
  - Element C: Clarify that a behavioral healthcare practitioner must be actively involved.
  - Element D: Align scoring with the requirement that the UM program is evaluated annually and updated (as necessary).

- **UM 8**: Remove Element A, which lists types of appeals covered in the scope of an NCQA review.
  - This information is expanded and reviewed in UM 8, Elements B and C.

- **UM 8**: Combine UM 8, Elements B and C to streamline requirements.

- **RR 4**: Make Element F consistent with Element B by adding a requirement to update hospital directory information within 30 calendar days of receipt of new information.

- **MEM 5**: Specify the frequency of collecting and analyzing data in Element D, factors 2–5.

Documents

Refer to Appendix 3: 2015 Additional Accreditation and Certification Product Updates for proposed changes.
Public Comment

Public Comment is integral to the development of all NCQA standards and measures. NCQA actively seeks thoughtful commentary and constructive criticism from interested parties. NCQA seriously considers all suggestions. Many comments lead to changes in our standards and policies and the review process makes our standards stronger and more worthwhile for all stakeholders.

In addition to the specific questions asked above in this document, NCQA requests reader thoughts and insights on global issues related to product updates.

- **Additional areas.** Do the standards align with organization services and stakeholder expectations? Are there gaps? Are there other opportunities to address the topics covered here in Health Plan Accreditation?

- **Scope.** Does the scope seem reasonable, given the current market?

We also request feedback on changes proposed for individual elements in the standards. You are asked to indicate if you **Support, Do not support** or **Support with modifications**. When you determine your level of support, please consider:

- Is this requirement reasonable, given current industry practices? If not, why not?

- Are the requirements (e.g., standards, intent statements, explanations) clearly articulated? If not, which areas should be clarified? Is further explanation needed? Should NCQA provide more examples?

- Does your organization have the necessary documentation to demonstrate compliance with the standard? If not, why not?

Refer to **Submitting Comments**, below, for details.

Documents

Draft changes to HPA 2015 are explained in detail in the following documents.

- **Appendix 1:** List of Proposed Measures for Health Plan Accreditation 2015.
- **Appendix 2:** Health Plan Accreditation 2015 Updates.

Submitting Comments

Submit all comments through NCQA’s Public Comment Web site ([publiccomments.ncqa.org](http://publiccomments.ncqa.org)). **NCQA does not accept comments via mail, e-mail or fax.**

**All comments are due by Thursday, April 3, by 5 p.m. ET.**

To enter comments:

1. Go to the Public Comment database.
2. Enter your e-mail address and contact information.
3. Select one of the following:
   - **2015 Health Plan Accreditation**
   - **2015 Additional Accreditation and Certification Product Updates**
4. Select the Topic, Standard and Element on which you would like to comment.
5. Select your support option (e.g., **Support, Do not support, Support with modifications**).
If you choose Do not support, include your rationale in the text box. If you choose Support with modifications, enter the suggested modification in the text box.

There is an 1,800 character limit for each comment. Comments are cut off at 1,800 characters. Please be brief and to the point in your feedback.

We suggest that you develop your comments in Word, in order to check your character limit and save a copy for reference. Use the “cut and paste” function to copy your comment into the text box.

Next Steps

The final 2015 Standards and Guidelines for the Accreditation of Health Plan Accreditation will be released in July 2014, following approval by the NCQA Standards Committee and the Board of Directors. Requirements will take effect July 1, 2015.

Plans coming forward for accreditation on or after that date must meet the new requirements.