Medicaid Accreditation
Concepts Input Survey
## Overview

**Our mission:** to improve the quality of health care

NCQA is dedicated to improving health care quality. Over 19 years of experience accrediting health plans have taught us that accountability through performance-based accreditation yields improvements in quality. Accredited Medicaid health plans perform better than non-accredited plans on HEDIS® performance measures of key interest including, controlling high blood pressure and cervical cancer screening. Currently 35% of health plans serving 10.5 million Medicaid lives are accredited by NCQA.

To improve quality and increase accountability through NCQA Accreditation, NCQA is evaluating its current approach to Health Plan Accreditation for Medicaid product lines. An updated approach will expand the definition of quality care for Medicaid’s diverse populations.

**Objectives of the Medicaid Accreditation evaluation**

The objective of NCQA’s Medicaid accreditation evaluation is to adapt our existing Health Plan Accreditation design, standards and measures to focus on the Medicaid population’s special needs. The Medicaid Accreditation evaluation will adapt accreditation to:

- Increase number of Medicaid enrollees in Accredited plans;
- Focus on needs of state Medicaid offices;
- Identify plans that are providing accessible, meaningful care and service to Medicaid populations; and,
- Allow high-quality plans to demonstrate their unique value proposition.

**Medicaid Accreditation Advisory Committee (MAAC)**

In June, NCQA convened the Medicaid Accreditation Advisory Committee (MAAC), a panel of leading experts on Medicaid managed care, to consider updates to NCQA’s Accreditation program for Medicaid health plans. The committee acts as a sounding board for proposed standards and the general approach to evaluation and serves as a forum for consensus building.

The first MAAC meeting focused discussion on:

- Consideration of Medicaid eligibility subgroups in accreditation;
- New and existing standard concepts; and,
- The role of existing, new and revised performance measures.

The MAAC’s feedback informed and directed the concepts included in this input survey.

**Development principles**

NCQA and the MAAC will develop and update requirements that:

- Drive quality improvement and value;
- Are based on evidence or strong expert consensus;
- Are feasible and not overly-burdensome;
- Hold the health plan accountable for something it can control; and,
- Consider the best source of evaluation for the concept (e.g., a standard or performance measures).
Public input is integral to the development of all NCQA standards and measures. NCQA actively seeks input from all interested parties during the development cycle of programs and routinely integrates such input into its programs. During development of the Medicaid Accreditation, NCQA will provide two formal opportunities for public input.

1. **Summer 2009:** The Concept Input Survey allows interested stakeholders to provide feedback on NCQA’s proposed areas of focus and draft requirement concepts. The survey also asks for health plans and state Medicaid offices to share data on their structure and requirements to help inform the evaluation and development process.

2. **Early 2010:** Public Comment allows interested stakeholders to provide feedback on development requirements and program design.

### Submitting Input

<table>
<thead>
<tr>
<th>Due Date</th>
<th>Responses must be received by <strong>5 pm ET on Friday, August 14, 2009,</strong> to be considered.</th>
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</table>
| How to Submit Comments | Submit all comments via the web survey tool link below.  
NCQA uses this method to streamline the process and to make tracking and assessing submitted comments more efficient. **NCQA does not accept comments via mail, e-mail or fax.**  
This document contains more detail and background than the survey tool. We recommend referring to the document as you complete the survey. |

### Next Steps

In the Fall of 2009, NCQA will draft updates to the accreditation program and develop new requirements. The concepts public input results, along with input from NCQA’s Medicaid Accreditation Advisory Committee, will inform the development. In September, committee members will review the public input in workgroup meetings that focuses on:

- Individuals who are dually eligible for Medicaid and Medicare
- Individuals with physically or developmental disabilities
- Individuals with mental illness or substance abuse disorders
- Primary Care Case Management
- Core accreditation standards

In the beginning of 2010, NCQA will release the proposed changes to Medicaid Accreditation for public comment and pilot testing. In the Spring of 2010, NCQA will seek approval for the updated program by NCQA’s Standards Committee and Board of Directors. NCQA plans to release the final accreditation requirements in July 2010. The requirements will go into effect July 2011.
Medicaid Accreditation Concepts Input Survey

State Medicaid offices have expressed interest in being able to take the characteristics of the Medicaid population into account when they are reviewing benchmark performance data. NCQA is also interested in better understanding the populations covered by accredited plans and plans that report HEDIS®. NCQA is seeking data to inform the Medicaid accreditation evaluation.

- **If you are a health plan, …**
  - How many individuals are enrolled in your Medicaid products?
  - How many Medicaid enrollees are included in the following groups? Please provide any additional data on your Medicaid enrollees you would like NCQA to consider.
    - Physically or developmentally disabled
    - Mental or substance abuse disorders
    - Low-income adults
      - Pregnant women
      - Single adults
    - Low-income children
    - Children’s Health Insurance Program (CHIP)
      - Children
      - Parents
    - Medicare/Medicaid dual-eligibles
  - Do you collect the following information on all of your Medicaid enrollees?
    - Income level (e.g., < 100% federal poverty level)
    - Race/ethnicity
    - Primary language data

- **If you are a state Medicaid office, …**
  - Select how the following groups are enrolled in capitated managed care (i.e., no enrollment, voluntary, mandatory). Please provide any additional data on your state’s Medicaid managed care enrollees you would like NCQA to consider.
    - Physically or developmentally disabled (non-Medicare/Medicaid dual eligible)
    - Mental illness or substance abuse disorders
    - Low-income adults
    - Low-income child
    - Children with special health care needs
    - Children’s Health Insurance Program (CHIP)
    - Medicare/Medicaid dual-eligibles
  - Does your state carve-out any of the following benefit services from capitated managed care?
    - Mental and behavioral health
    - Pharmacy
Medicaid Populations

The Medicaid Accreditation Advisory Committee recommended that NCQA pay special attention to three Medicaid populations: physically or developmentally disabled, mental illness or substance abuse disorders, Medicare/Medicaid dual-eligibles. These groups are among the most vulnerable of the Medicaid population and account for a large portion of Medicaid expenses.

- What access and coordination of care issues are associated with these populations that NCQA should evaluate?
- What methods/measures for tracking outcomes and functional status are used for these populations?
- What other issues are unique to these populations?
- Are there other segments of the Medicaid population NCQA should consider establishing separate accreditation requirements to evaluate?

Standards Development Approach

NCQA is focusing on certain development approaches when updating and creating standards for Medicaid health plans.

- Rank the importance of the approach to you in an updated Medicaid accreditation, 5 being very important and 1 not very. Please explain.
  - **Maintain/enhance deemable standards:** The Balanced Budget Act of 1997 (BBA) established requirements for states to ensure the quality of care delivered through their Medicaid managed care contracts. The regulations specify standards in three areas for Medicaid-contracting MCOs: structure and operations, access to care and quality measurement and improvement. NCQA has crosswalked these requirements to NCQA standards and HEDIS and CAHPS measures. The crosswalk and details on the requirements are included in NCQA’s *Medicaid Managed Care Toolkit*.
  - **Develop new standards to meet additional deemable requirements:** NCQA can create or revise standards to meet additional federal oversight requirements (i.e., availability of services).
  - **Draw from existing Culturally and Linguistically Appropriate Services (CLAS) standards not included in Health Plan Accreditation for Medicaid plans:** NCQA is currently developing voluntary health plan standards that assess a health plan’s work to reduce disparities by offering CLAS. The draft standards include data collection and protection of race, ethnicity and language data; access and availability of language services; network diversity; reducing health care disparities.
  - **Draw from existing Special Needs Plans (SNP) standards not included in Health Plan Accreditation for Medicaid plans:** The Centers for Medicare and Medicaid Services (CMS) contracted with NCQA to evaluate structure and process of SNPs. SNPs are a Medicare managed care plan focused on certain vulnerable groups of Medicare beneficiaries: the institutionalized, dual-eligibles and beneficiaries with severe or disabling chronic conditions. These beneficiaries are typically older, with multiple comorbid conditions, and thus are more challenging and costly to treat. Standards evaluating the SNP plans include care transitions and coordination of Medicaid and Medicare coverage.
  - **Draw from existing Member Connections standards not included in Health Plan (HP) Accreditation for Medicaid plans:** Medicaid products of health plans are currently not evaluated against Member Connection standards. Member
Connection standards include health appraisals, self-management tools and pharmacy benefit information. Preliminary research with health plans suggests that Medicaid plans are increasing providing these services and should be evaluated on the services.

- **Develop new standards that address significant cost drivers in Medicaid:** These standards could focus on monitoring of hospitalizations and emergency department overuse.

- **Develop new standards that focus on the special needs of Medicaid sub populations**
  - Physically or developmentally disabled
  - Mental illness or substance abuse disorders

- Medicare/Medicaid dual-eligibles Rank the importance of including the following CLAS standard categories in an updated Medicaid accreditation, 5 being very important and 1 not very.
  - **Data collection and protection of race, ethnicity and language data:** The organization gathers and protects member race/ethnicity and language data using standardized methods.
  - **Access and availability of language services:** The organization provides materials and services in the languages of its membership.
  - **Network diversity:** The organization maintains a network that reflects the diversity of its membership and is responsive to member needs and preferences.
  - **Reducing health care disparities:** The organization uses member race/ethnicity and language data to assess the existence of disparities and to focus quality improvement efforts towards improving the provision of culturally and linguistically appropriate services and decreasing health care disparities

- Rank the importance of including the following MEM standards in an updated Medicaid accreditation, 5 being very important and 1 not very.
  - **Health Appraisals:** The organization helps adult members manage their health through the provision of an HA, discloses how the information will be used and protects it in accordance with privacy policies.
  - **Self-management Tools:** The organization provides self-management tools to help members stay healthy and reduce risk.
  - **Functionality of Claims Processing:** The organization provides members with timely and accurate information about their claims.
  - **Pharmacy Benefit Information:** The organization provides members with the information they need to understand and use their pharmacy benefit.
  - **Personalized Information on Health Plan Services:** The organization makes it as easy as possible for members to make decisions about how best to use their benefits.
  - **Innovations in Member Services:** The organization uses technology to improve member service.
  - **Encouraging Wellness and Prevention:** The organization promotes member wellness and prevention of illness, and measures access to wellness and prevention services.
• From the list below, identify at most 3 cost drivers health plans should be expected to address.
  - Emergency department overuse
  - Avoidable hospitalizations
  - Appropriate lab follow-up
  - Multiple medication use (polypharmacy)
  - Appropriate nursing home use
  - Others

Patient-Centered Medical Home (PCMH)
The patient-centered medical home is a model for care provided by clinical practices that seeks to strengthen the physician patient relationship by replacing episodic care based on illnesses and patient complaints with coordinated care and a long term healing relationship. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

• Select the strategies all Medicaid health plans should be expected to use to support practices to function as a medical home. (You may select more than one.)
  - Pay for performance
  - Reimbursement that reflects additional efforts (e.g., reimbursement for changes to technology infrastructure)
  - Information sharing on best practices (e.g., dissemination of effective care management tools)
  - Sharing information back to medical home (e.g., claims data)
  - Others

Current Health Plan Accreditation Standards
NCQA is asking for input on what 2010 Health Plan Accreditation standards should be considered core or integral for all Medicaid health plans.

• Initial feedback from health plans and state Medicaid offices encouraged NCQA to continue to meet federal requirements and meet more requirements to further reduce regulatory burden. NCQA considers the accreditation standards that fully meet federal requirements to be core elements. Do you agree with this approach?

• Listed in the web-survey tool are all 2010 Health Plan Accreditation elements that do not meet a deemable federal requirement. NCQA is considering removing non-core elements from 2011 Health Plan Accreditation. Please select the elements you feel are NOT core or integral for all Medicaid health plans.
<table>
<thead>
<tr>
<th>Measure Strategy</th>
<th>Currently health plan performance on HEDIS® measures are scored as a part of accreditation. In the first update to Medicaid accreditation released in July of 2010, NCQA does not plan any significant changes to the HEDIS® measures to be scored in accreditation. NCQA will continue to develop measures that relate to Medicaid populations, with the thought of scoring them in accreditation at an appropriate stage. Measure sets currently in development include well-child care, overuse of medical services and care coordination.</th>
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<td></td>
<td>• Rank the importance of including the following developing and undeveloped measurement areas in accreditation</td>
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<td>- Comprehensive well-child care</td>
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<td>- Women’s preventive care</td>
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<td>- Dental care access</td>
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<td>- Oral health assessment</td>
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<td>- Screening for substance abuse</td>
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<td>- Perinatal care</td>
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<td>- Atypical antipsychotic prescribing</td>
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<td>- Underuse of needed care</td>
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<td>- Health literacy</td>
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<td>- Others</td>
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<td>NCQA has heard from Medicaid health plans and state Medicaid offices that HEDIS® measures continuous enrollment requirements are prohibitive to data submission because of Medicaid populations cycling in and out of health plans.</td>
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<td>• For health plans, approximately what percentage of your Medicaid enrollees are left out of HEDIS® denominators because of the continuous enrollment specification?</td>
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<td></td>
<td>• Please provide any additional information you would like NCQA to consider regarding Medicaid HEDIS® continuous enrollment specifications</td>
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