NCQA Medicaid Managed Care Toolkit

2016 Health Plan Accreditation Standards

Effective July 1, 2016 – June 30, 2017

Assistance for State Agencies in Using NCQA Accreditation for Medicaid Managed Care Oversight & the State Quality Strategy

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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.

NCQA Customer Support: 888-275-7585
NCQA Policy Clarification Support (PCS): http://ncqa.force.com/pcs/login

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Summary

This toolkit provides guidance to state Medicaid program staff on the components of NCQA Accreditation results that can be used under the non-duplication provision and reported within a state's Quality Strategy.

For the 2016 Toolkit we reflect analysis of alignment with the federal External Quality Review deemable areas in effect prior to the implementation of the changes and updates reflected in the Mary 2016 Medicaid Managed Care Final rule. The 2017 Toolkit, scheduled for release in Fall 2017, will be reorganized to reflect the changes from the final rule.

Non-Duplication

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 maintains 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 align with a majority of federal requirements covered. States can use the crosswalk to reduce duplicative reviews and streamline oversight of managed care plans.
NCQA partners with state agencies	NCQA's State Affairs staff routinely works with states to address questions about NCQA's Health Plan Accreditation program, reporting audited Healthcare Effectiveness and Data Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1] results and maximizing accreditation as a component of the state's health plan oversight and Quality Strategy.
Crosswalk Analysis	The crosswalk analysis includes portions of the language from relevant standards that make up the NCQA 2016 Standards and Guidelines. For a detailed understanding of each standard, element, and factor and how each are evaluated as part of the accreditation process, please reference the 2016 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.

[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)), maximize the use of the non-duplication provisions and synchronize plan state and accreditation compliance efforts.

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

NCQA annually compares relevant federal requirements with our Health Plan Accreditation standards. We continue to see that NCQA standards are similar to a majority of the federal requirements that EQROs review and evaluate. This comparison is found under the *438.204(g) Deemable Regulations* 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 improvement projects (PIP)

Medicaid plans are required to engage in performance improvement projects that must be validated by the EQRO. NCQA places significant weight on the improvement of HEDIS and CAHPS results in accreditation scoring. NCQA Health Plan Accreditation derives 50% of the plan's accreditation score from annual submission of HEDIS and CAHPS performance. NCQA supports a focus on improvement in HEDIS and CAHPS results which we believe is the most standardized and transparent method for assessing a health plan's quality improvement efforts. Many states use the HEDIS and CAHPS measures to support their PIPs.

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, the Office of Personnel Management and the Centers for Consumer Information and Insurance Oversight), and other purchasers use or require Audited HEDIS measures for quality improvement, benchmarking and pay for performance.

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. The toolkit includes analysis and direction to states on when accreditation can be used and when a state or its EQRO needs to conduct additional review for a deemable element. Since the 2005 launch of the Toolkit, NCQA's standards have continued to maintain a high equivalency[2] with a majority of the federal deemable requirements.

Table 2: Equivalency of Federal Requirements*

Regulation Category	2016 Equivalence**
Quality Measurement and Improvement (438.236, 240, 242)	89%
Structure and Operations (438.214, 218, 224, 226, 228, 230)	91%
Grievances 438.400 (included by reference in 438.228 above)	73%
Information Requirements 438.10 (included by reference in 438.218 above)	63%
Access to Care (438.206, 207, 208, 210)	88%

*Based on 2016 NCQA Health Plan Accreditation.

** Percent of the eligible federal requirements within this category that are comparable to NCQA standards. The percentages listed in Table 2 include NCQA standards that meet or partially meet the federal requirements.

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

Per CMCS, please submit requests for technical assistance related to EQR or State Quality Strategies to CMS at ManagedCareQualityTA@cms.hhs.gov, including questions related to communicating process changes to the EQRO. Additional information on managed care quality strategies is available below:

General EQR overview: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/quality-of-care-external-quality-review.html

EQR Technical reports: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/External-Quality-Review-Technical-Reports.html

[2]Equivalency 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 that meet or partially meet the intent of the regulation. Regulations that are not applicable to NCQA accreditation (e.g. state functions) are excluded from the calculation. Maximum potential equivalency (100%) is state specific.

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 State Affairs Department can assist state Medicaid agencies in this process.

Assistance from NCQA's State Affairs Department

NCQA's State Affairs Department partners with state agencies to help align the state's quality strategy and operational standards with NCQA's requirements for performance improvement and measurement. We are 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 staff can work with your agency to answer crosswalk questions related to interpreting NCQA standards and share examples from states making the most of accreditation.

Timelines/Language

In states that mandate NCQA Accreditation, our goal is to support state Medicaid agencies through the timeline development process and ensure plans meet the state's accreditation deadlines. 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 State Affairs Department frequently meets with state agencies and serves as a liaison to address questions about the NCQA accreditation and performance measurement processes. Depending on the type of information needed we can meet in person, via phone or Web-Ex.

General Questions

Technical Assistance. NCQA's State Affairs and Accreditation Policy staff work together to support states using NCQA's evaluation programs (Accreditation, HEDIS, CAHPS, PCMH, etc.). The Policy Clarification Support (PCS) system is a free resource to the public that allows NCQA to manage technical questions and provide a coordinated and timely response.

PCS - http://ncqa.force.com/pcs/login

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.

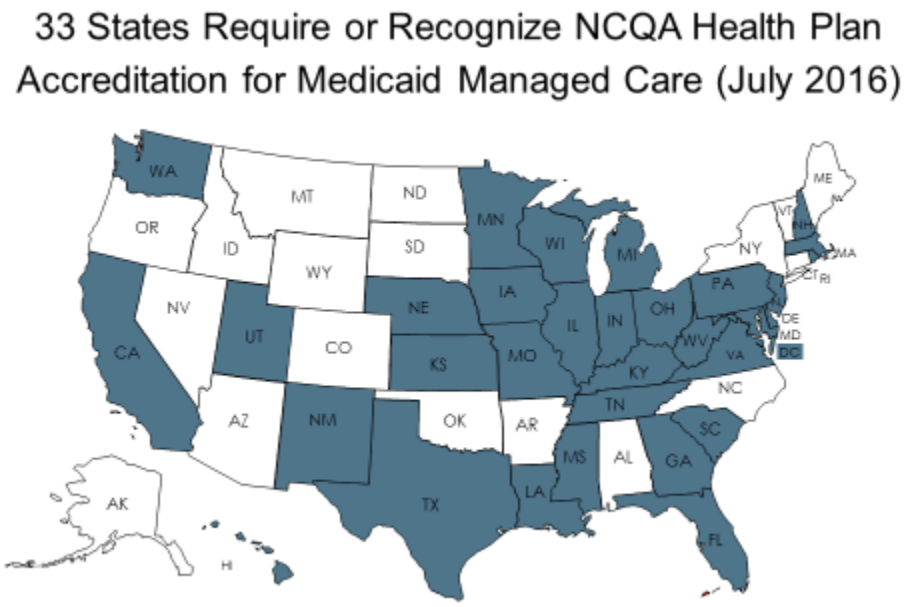
All accreditation results are publicly available enabling state purchasers to make value-based contracting decisions and enabling patients to have quality information upon which to choose a plan (see NCQA Public Reporting below). Patients benefit from the added transparency in the managed care marketplace driven by NCQA Accreditation.

NCQA's accreditation program emphasizes performance measurement through quantitative analysis of health outcomes among enrollees. NCQA's HEDIS performance measures allow for comparisons across organizations, agencies and states. 50% of a plan's accreditation score comes from annual reporting of audited[3] HEDIS and CAHPS results.

In 2014, 172 million Americans were enrolled in health plans that use HEDIS to measure and report on the quality of care[4]. Note, 2015 numbers will be released in late summer 2016.

State Use of Accreditation

As of July 2016, 42 states, including 33 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. Go http://www.ncqa.org/public-policy/working-with-states for the detailed list of state Medicaid use of Accreditation.



[3] NCQA Health Plan Accreditation requires annual submission of HEDIS and CAHPS data validated by an NCQA Certified HEDIS Compliance Audit™. The NCQA HEDIS Compliance Audit indicates whether a managed care organization has adequate and sound capabilities for processing medical, member and provider information as a foundation for accurate and automated performance measurement, including HEDIS reporting.

Requiring NCQA Accreditation

The trend toward use of accreditation continues to grow. Currently, 24 states require NCQA Health Plan Accreditation for Medicaid managed care plans (Delaware, District of Columbia, Hawaii, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Mississippi, Missouri, Nebraska, New Hampshire, New Jersey, New Mexico, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Virginia, Washington and West Virginia).

Recognizing Accreditation

States can also choose to deem accreditation from plans that have voluntarily chosen to seek accreditation. The Medicaid programs in 9 states use NCQA Accreditation to demonstrate compliance with components of the External Quality Review and state-specific requirements. States include: California, Minnesota, Texas, Utah, Wisconsin.

In addition, several states require plans to be accredited and recognize NCQA HPA: Iowa, Florida, Georgia, and Michigan.

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.

Integrating LTSS: Medicaid Managed Long-Term Services & Supports (MLTSS)

Many states currently entrust LTSS coordination and management to managed care organizations (MCOs). Some MCOs offer LTSS case management services directly; others delegate services to community-based organizations. The number of states with managed LTSS (MLTSS) programs increased from 8 in 2004 to 18 in 2015, and at least 9 more states are planning to implement or expand MLTSS. Many MCOs that are expanding into MLTSS may be unfamiliar with the providers and care delivery system. The service capacity of community-based organizations is an important consideration for many MCOs exploring partnerships.

MCOs and organizations that coordinate LTSS should implement best practices for person-centered care planning and effective care transitions, and for measuring quality improvement to support people living optimally in their preferred setting.

- The Affordable Care Act mandates that states develop community-based, person-centered LTSS systems.
- States now require MCOs to use a person-centered planning process. This was formalized through the Centers for Medicare & Medicaid Services 2016 Final Medicaid Managed Care Rule.
- Effective care transitions help prevent medical errors, duplication of services an unnecessary hospitalizations and readmissions.
- They also help bolster consumer choices and lead to more effective utilization of resources.

Health Plan Accreditation: LTSS Distinction – NEW

In 2016, NCQA is launching the LTSS Distinction program to help Medicaid Managed Care Health Plans, offering comprehensive health plan benefits, demonstrate their ability to effectively coordinate Long-Term Services & Supports for their beneficiaries.

LTSS Distinction is Optional. The LTSS Distinction standards are an optional module within NCQA's existing Health Plan (HP) and Managed Behavioral Health Organization (MBHO) Accreditation requirements; similar to NCQA's Multicultural Health Care Distinction Program. Health plans and MBHOs that elect to complete the LTSS module will have the opportunity to earn an Accreditation status with LTSS Distinction. Plans and MBHOs that earn Distinction will have this status listed on NCQA's public directory.

Recommend Requiring LTSS Distinction. Since implementation of managed long term services and supports is varied across the country, we have not made LTSS Distinction a mandatory part of the health plan accreditation review. However, for states integrating LTSS into managed are, the new LTSS Distinction module will support the goals of evaluating plans against the CMS guidelines finalized in the recent Medicaid Managed Care Rule. If your state intends to require plans responsible for LTSS to be accredited by NCQA, we recommend adding the LTSS Distinction module to your expectation to your contract requirements.

Accreditation of Case Management for Long-Term Services & Supports (LTSS) – NEW

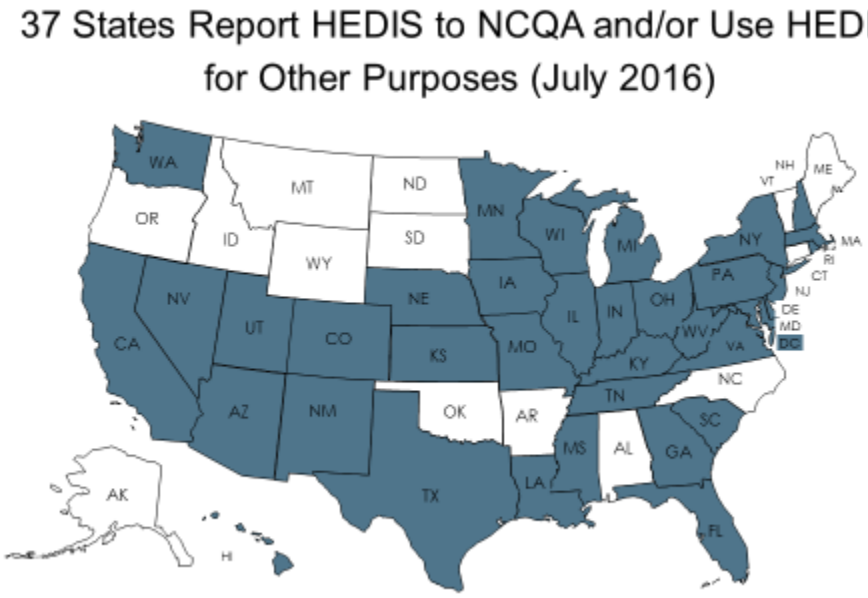
In 2016, NCQA is launching Accreditation of Case Management for long-term services and supports (LTSS), which accredits organizations that demonstrates the ability to effectively coordinate long-term services and supports. NCQA's standards provide a framework for organizations to deliver efficient, effective person-centered care that meets people's needs, helps keep people in their preferred setting and aligns with state and MCO requirements. The standards are a roadmap for improvement—organizations can use them to conduct a gap analysis and align their improvement activities in the areas that are most important to individuals, payers and states. Earning NCQA Accreditation can help your organization:

- **Become more efficient.** A focus on coordinated care, training and measurement can help organizations reduce errors and duplicated services.
- **Integrate care better.** Standards can help organizations improve communication between individuals, caregivers, providers, payers and other organizations coordinating care.
- **Provide person-centered care.** Standards focus on person centered services, which can lead to better care planning and monitoring.
- **Support contracting needs.** Standards align with the needs of states and MCO's. NCQA-Accredited organizations demonstrate that they're ready to be trusted in coordinating LTSS services.

To learn more about Accreditation of Case Management for LTSS, visit www.ncqa.org/cmltss.

State Use of HEDIS

As of July 2016, 41 states, including 37 Medicaid programs use HEDIS. For states that use HEDIS for benchmarking, pay for performance and public reporting it is critical that states require plans to submit audited HEDIS and CAHPS results to NCQA. A uniform requirement across plans supports fair, apples to apples comparisons of plan quality. States, like California, have also used HEDIS results to build consumer report cards that help state residents make more informed health insurance purchasing decisions. Go to http://www.ncqa.org/public-policy/working-with-states for the detailed list of state Medicaid use of HEDIS.



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.

2016 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)

2016 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)

State Innovation Model (SIM) Initiative

The Center for Medicare and Medicaid Innovation (CMMI) launched the SIM Initiative to provide states with support to develop and pilot new multi-payer delivery system transformation efforts. Many states are focusing on new payment arrangements (e.g., bundled payments, shared savings), medical homes and accountable care organizations, often building on existing systems and initiatives that have been in place and demonstrated success. NCQA is actively engaging with states to provide our expertise as states design and plan for new measurement and accountability models.

Patient-Centered Medical Home Recognition

The Patient Centered Medical Home is a model of care that holds promise for better health care quality, improved involvement of patients in their own care and reduced costs. 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 Patient-Centered Medical Home (PCMH) Recognition Program.

The Current Standards – PCMH 2014. To maximize the efforts of practices seeking recognition, NCQA released an updated version of the Patient-Centered Medical Home (PCMH) standards in March of 2014.[5] These standards further promote the integration of behavioral health, focus practice care management efforts on high-needs patients and align with Stage 2 of Meaningful Use. NCQA will release the next cycle of PCMH standards, effective March 2017, in late summer 2016.

NCQA Redesigns PCMH Recognition. In response to published literature critiques and recommendations we have received from the original framers of the Joint Principles, groups representing other clinicians, and the doctors, nurses, care coordinators and other team members that live the PCMH model every day, we are releasing an ambitious PCMH Recognition Program Redesign for 2017. The overarching objective of this redesign is to enhance the value of NCQA recognition programs for patients and their families, clinicians, employers, payers, and other stakeholders (such as federal and state agencies). Key components include:

- Strengthening the link between recognition and practice performance on quality, cost, and patient experience metrics;
- Increasing practice engagement while reducing non-value added work;
- Leveraging practices' investment in health information technology to help support PCMH recognition; and
- Aligning PCMH recognition activities with other reporting requirements

[5] The 2014 PCMH™ Standards and Guidelines are available for free on NCQA's Website.

NCQA PCMH 2017 include the following specific changes:

- Provide more guidance to practices through new channels, including live support, online resources and improved customer service;
- Introduce a streamlined annual check-in for recognized practices rather than requiring a full documentation review every three years;
- Use information generated in the course of daily clinical care to support the recognition process; and,
- Redesign our online survey tool to be more user-friendly and efficient.

State Level Financial Incentives for PCMHs. Formal PCMH initiatives have grown significantly since the genesis of the concept. NCQA's 2017 PCMH landscape analysis indicates 149 initiatives (public, private, multi-payer) and organizations that support NCQA PCMH recognition through financial and/or non-financial incentives. Many of these initiatives are spearheaded by state governments and Medicaid programs are often key participants. Many states are addressing primary care redesign in their State Innovation Model (SIM) and Delivery System Reform Incentive Payment Programs (DSRIP). This is not surprising given the growing body of evidence that suggests PCMH initiatives can improve quality, raise patient satisfaction and lower costs.[6,7,8]

Federal Level Incentives. In addition, the federal government has also expressed interest in furthering support for medical homes. The Health Resources Services Administration helps Federally-Qualified Health Centers pursue practice transformation. CMS has piloted the model in various demonstrations, including the Advanced Primary Care Practice Demonstration and the Comprehensive Primary Care Initiative. In April 2016, CMS announced the Comprehensive Primary Care Plus Initiative, which is the successor to the Comprehensive Primary Care Initiative. CPC Plus is a five-year initiative that will begin January 2017.

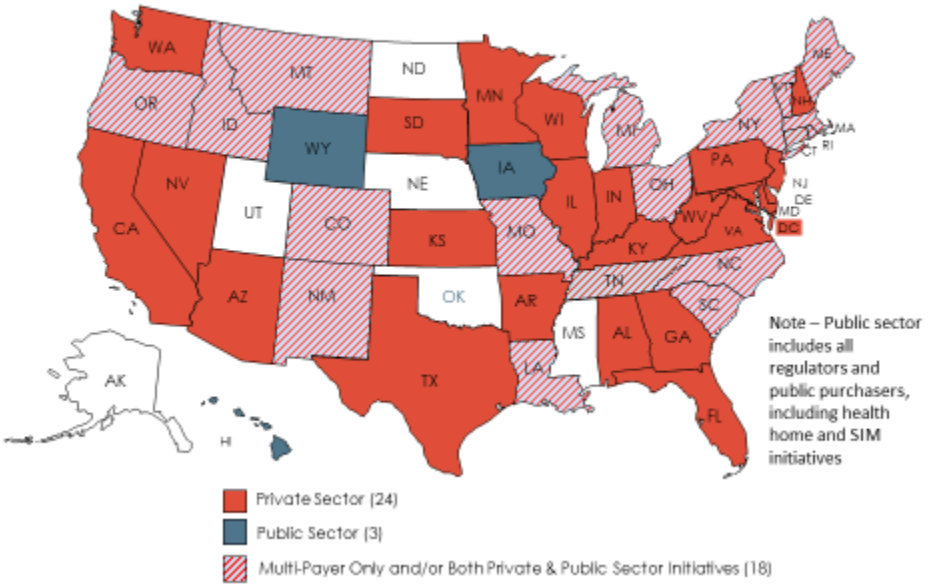
In April 2016, CMS also released its Notice of Proposed Rule Making for implementation of the Medicare Access and CHIP Reauthorization Act (MACRA). CMS' proposed MACRA rule specifically names NCQA PCMH & PCSP practices as earning full Clinical Practice Improvement Activity credit (15% weighting). Clinicians not in recognized PCMH/PCSPs or Alternative Payment Models (APMs) do not get any automatic CPIA credit and may not merely attest that they are PCMH or PCSPs. Instead, they must report on individual CPIA activities to earn points toward credit.

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." Four states (Idaho, Iowa, Maine, Missouri) included NCQA PCMH in their program participation criteria because of its flexibility for application with the complex populations being served in the Health Home program.

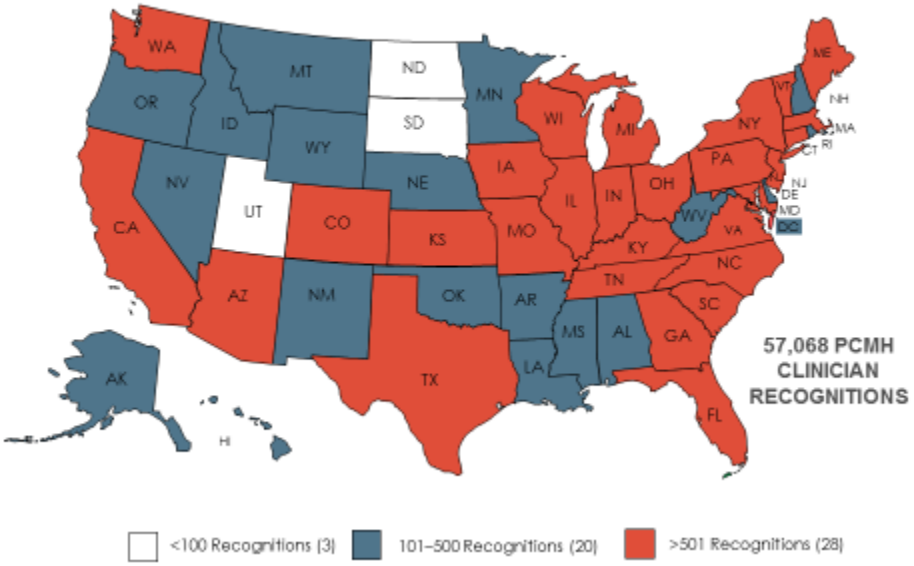
In addition, states are exploring NCQA's Patient-Centered Specialty Practice Recognition program which builds out the medical home neighborhood to include accountability of specialists in coordinating care. This is particularly relevant given the focus on integrating behavioral health and primary care.

[6] Raskas, Latts et al. Early Results Show WellPoint's Patient-Centered Medical Home Pilots Have Met Some Goals for Costs, Utilization, and Quality. *Health Affairs* September 2012 31:2002-2009
[7] DeVries et. al, Impact of Medical Homes on Quality, Healthcare Utilization, and Costs, *American Journal of Managed Care* September 2012, 18(9):534-544
[8] Patient Experience Over Time in Patient-Centered Medical Homes, Kern, American Journal of Managed Care, May 2013

45 States Require or Recognize NCQA PCMH Recognition for a PCMH Initiative (July 2016)



NCQA PCMH Clinician Recognitions (July 2016)



Accountable Care Organization Accreditation

As states examine new models for organizing care, many are looking to the accountable care model. NCQA developed the Accountable Care Organization (ACO) Accreditation program to provide a roadmap for provider-led organizations to demonstrate their ability to reach the triple aim: reduce cost, improve quality and enhance the patient experience. For states, it can be used to set clear expectations for quality for their ACOs.

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
7. Performance Reporting and Quality Improvement

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.

Additional NCQA Resources for States

Quality Solutions Group

As a contractual services arm of NCQA, the Quality Solutions Group (QSG) provides customized services to states. QSG brings together NCQA experts and seasoned professionals with the right mix of skills and expertise to support initiatives in a variety of areas:

- Performance measure development and implementation, including electronic Clinical Quality Measures.
- Patient-centered medical home, practice transformation and electronic health records.
- Benchmarking, comparative analysis and identification of high performers and best practices.
- Innovative approaches to measuring and evaluating vulnerable populations using patient-reported outcomes.

When you work with QSG, you have access to NCQA's experience in performance measurement, program development and operations. QSG:

- Develops and adapts performance measures for diverse settings using varied data sources, including electronic clinical data.
- Promotes the effective use of performance measurement and translates data into actionable information (e.g., customized performance reports).
- Leverages, on your organization's behalf, NCQA's proven evaluation methods, Web-based data submission systems and extensive data management capabilities.
- Designs and conducts learning programs that offer critical support to your initiatives. We can help increase participation by designing programs that offer continuing education credits.
- Analyzes quality data to identify high-performing organizations—and how they got that way.

QSG services, at a glance.

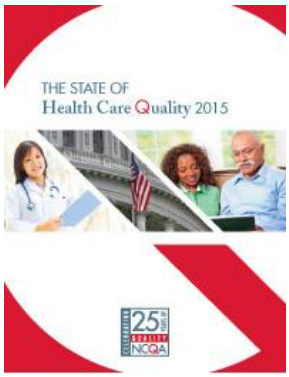
Other NCQA Programs

In addition to HPA and HEDIS performance measurement, NCQA's other accreditation, certification, and recognition programs can serve as complementary or alternative tools for driving quality and value. Those programs include the following:

- Provider Recognition Programs:
  - Diabetes Provider Recognition Program
  - Heart and Stroke Recognition Program
  - Patient-Centered Medical Home Recognition Program
  - Patient-Centered Specialty Practice Recognition
- Case Management Accreditation
- 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

NCQA Public Reporting

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



The 2015 State of Health Care Quality Report includes NCQA's latest findings about the nation's health care system. NCQA produces the State of Health Care Quality Report to focus on major quality issues the U.S. faces and to support the spread of evidence-based care. This report documents performance trends over time, tracks variation in care and recommends quality improvements.

The report synthesizes data collected throughout 2015 (measurement year 2014) by NCQA's Healthcare Effectiveness Data and Information Set (HEDIS®), health care's most widely used performance improvement tool. The report summarizes the quality and consumer satisfaction results of health plans covering more than 172 million people, or 54 percent of the U.S. population.

The 2016 State of Health Care Quality Report will only be available online (no longer available in print book or PDF). NCQA will update measure text descriptions (if they have changed) and provide text descriptions for new measures. NCQA will also update the data (i.e., adding 2015 rates as a new top row in display tables). However, NCQA will no longer include an executive summary or other written analysis.

NCQA Health Insurance Plan Ratings

NCQA's Health Insurance Plan Ratings 2016–2017 lists private, Medicare and Medicaid health insurance plans based on their combined HEDIS, CAHPS and NCQA Accreditation standards scores.

The NCQA Accreditation status used in these ratings is as of June 30, 2016. With NCQA's permission, Consumer Reports references the NCQA Health Insurance Plan Ratings on its Web site and in the November issue of Consumer Reports magazine, ensuring that this valuable information reaches millions of consumers.

NCQA's Health Insurance Plan Ratings 2016–2017 uses the new Ratings methodology which classifies plans into scores from 1-5 in 0.5 increments–-a system similar to CMS' Five-Star Quality Rating System.

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

Quality Compass is a national database containing commercial, Medicaid and Medicare data and serves as an indispensable tool used for selecting health plans, conducting competitor analysis, examining quality improvement and benchmarking plan performance.

Quality Compass includes audited, publicly reported data at the health plan submission level and benchmarks are offered at National, Regional and State and are inclusive of both public and non-publicly reported health plan data. It contains information for all reportable HEDIS measures[9]. Commercial and Medicaid versions are based on HEDIS Volumes 2 and 3, including latest HEDIS/CAHPS measures (does not include first-year measures), while Medicare only includes HEDIS.

Provided in this tool is the ability to generate custom reports by selecting plans, measures, and benchmarks (averages and percentiles) for up to three trended years. Results in table and graph formats offer simple comparison of plans' performance against competitors or benchmarks. Data are available for purchase in an online format.

- Commercial data released annually in July.
- Medicaid data released annually in September
- Medicare data released annually in October.

To learn more about licensing Quality Compass, please visit http://www.ncqa.org/HEDISQualityMeasurement/QualityMeasurementProducts/QualityCompass.aspx

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

APPENDIX 1

ANNOTATED FEDERAL REGULATIONS

Note: The citations below reflect current MMC regulations, not those effective under the MMC final rule (May 2016)

The 2017 Toolkit will reflect the MMC final rule.

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. However, the 2016 Medicaid Managed Care Final Rule (effective July 2017) includes PIPs and Performance Measure activities as deemable.

(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.[16]

438.240(b)(1)[17]
(1) The State must require that each MCO and PIHP… conduct performance improvement projects[18] 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 areas[19], and that involve the following:

(i) Measurement of performance using objective quality indicators.

[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.
[16] State can define PIPs to include HEDIS or QI standards.
[17] This section defines what the state requires from plans and consequently, what must be validated through the EQR process.
[18] 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
[19] States can choose measures from HEDIS/CAHPS to meet the intent of paragraph D.

(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.

(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.

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).[20]

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.

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[20] Validation of performance measures may be done via NCQA's HEDIS Compliance Audit. NCQA requires a HEDIS Compliance audit for all data reported to NCQA and used in Quality Compass Benchmarks. Audits paid for by the plan do not meet the independence criteria and therefore would not qualify the state for the enhanced Federal Medicaid funding.

If the state contracts with an EQRO to facilitate measure validation, they are eligible for the full 75 percent federal match associated with the audit costs and expenses. Several current EQROs are also licensed HEDIS Compliance auditors.

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(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).[21]

§438.204[22]
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)[23]

[21] 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.

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

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

APPENDIX 2

GLOSSARY OF TERMS

Tab References	
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.
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.
Information requirements	Information Requirements are incorporated by reference into the deeming regulation under 42 CFR 438.204(g).
Grievances	Grievances are incorporated by reference into the deeming regulation 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.
Partially Met	NCQA has a requirement but some of the federal requirements are not included in NCQA's accreditation survey and the state or EQRO must conduct review for such elements.
Not Met	NCQA does not have a standard that is similar to the federal requirement.
Not Applicable (NA) - State Function	The federal regulation is a requirement that the state must meet and is not a function that can be included in accreditation.
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.
Not Applicable (NA) - State Function	The federal regulation is a requirement that the state must meet and is not a function that can be included in accreditation.
NCQA Accreditation Survey Types	
Interim	Interim Survey is for plans that need accreditation before or right after they open for business. It focuses on policies and procedures, does not include HEDIS/CAHPS reporting and is valid for 18 months – half as long as the other options.
First	First Survey is for plans new to NCQA, and leads to accreditation that is valid for 3 years. HEDIS/CAHPS reporting is required only in year 3 of accreditation. This helps prepare health plans for Renewal requirements.
Renewal	Renewal Survey is available to NCQA-Accredited plans seeking to extend their accreditation another 3 years. HEDIS/CAHPS reporting is mandatory and plans are scored based on their performance results
NCQA Definitions	
Appeal	NCQA defines appeal as request to change an adverse decision made by the organization (the are covered by NCQA's UM requirements). A member or authorized representative of a member may appeal any adverse decision.
Complaint	NCQA defines complaint as an oral or written expression of dissatisfaction. NCQA RR standards align with what Medicaid defines as Grievances.

APPENDIX 3

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.

The 2016 Crosswalk includes NCQA's 2016 Health Plan Accreditation Standards, which are valid for accreditation surveys taking place between July 1, 2016 and June 30, 2017. For accreditation surveys taking place between July 1, 2015 and June 30, 2016, please refer to the 2015 Medicaid Managed Care Toolkit and Crosswalk and NCQA's 2015 Health Plan Accreditation Standards and Guidelines. NCQA's State Affairs Department is available to help states develop a comparison of their requirements to NCQA standards from the applicable standards year.

NCQA shares the Toolkit each year with 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.