Overview of Proposed Standards for a New Accreditation Program:

Health Equity Accreditation Plus

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Health Equity Accreditation Plus Overview

NCQA's Mission: Improve the Quality of Health Care

NCQA is dedicated to improving the quality of health care.

For more than 30 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. Today, approximately 176 million Americans are enrolled in an NCQA-Accredited health plan.

Health Equity Accreditation Plus: Development Process

The following sections provide an overview of NCQA's existing Health Equity Accreditation program and a detailed description of a proposed new program: Health Equity Accreditation Plus. Refer to *Appendix 1: Standards Proposed for Health Equity Accreditation Plus* for the full set of draft standards.

In addition to NCQA's traditional public comment period, development of Health Equity Accreditation Plus is supplemented with a highly collaborative process that incorporates guidance and feedback through diverse audiences and methods:

- *Advisory committee.* NCQA is collecting ongoing guidance from a special advisory committee of experts who represent diverse backgrounds, geographies and health care perspectives, from health plans to state agencies, community-based organizations (CBO) and the medical delivery system.

- *Pilot.* From fall 2021 through spring 2022, NCQA will test the content of the standards and the customer survey experience with 10 health plans and health systems. Feedback will help NCQA refine the standards and survey process.

- *CBO Roundtable.* In November 2021, NCQA will convene a roundtable of CBOs to identify and mitigate unintended consequences or potentially adverse impact of Health Equity Accreditation Plus standards on CBOs and other organizations.

- *State engagement.* NCQA will continue to engage state agencies in the program, collecting feedback to inform the content of standards, strengthening buy-in of NCQA's health equity strategy and identifying ways for states to support organizations seeking both Health Equity Accreditation and Health Equity Accreditation Plus.

The Quality and Equity Connection

Three core ideas drive NCQA's work on health equity:
1. High quality care is equitable care.
2. There is no quality without equity.
3. Equity should be built into all NCQA programs.

Equitable care is defined by structures, processes and outcomes that do not vary in quality because of individual characteristics or identities such as race/ethnicity, language, gender identity, sexual orientation, age, religion, aspect of disability or socioeconomic status.[1] Inequities in care are "produced and sustained by deeply entrenched social systems that intentionally and unintentionally prevent people from reaching their full potential," including racism, sexism, classism, trans or homophobia, ableism, xenophobia and others.[2] These "isms" are pervasive in American institutions and systems whose policies and practices affect the distribution of power and resources (social, medical, economic and environmental), and result in inequitable outcomes for individual and community health. They are also directly perpetuated and exacerbated by health care institutions through technology, policies and practices and technology that either benefit or disadvantage, engage or exclude, support or limit access, and encourage or discourage individuals in ways that result in inequitable care.

Although every organization has a responsibility to examine and improve how its own policies, practices and technology perpetuate or exacerbate health inequities, mitigating the adverse effects of health inequities requires collaboration across the health care industry, as well as beyond it, into communities they serve and at the state and federal levels. State Medicaid and Exchange policymakers, along with the federal government, are prioritizing health equity as a fundamental responsibility of the health care system. As of August 2021, six state agencies' contracts require NCQA's MHC Distinction (now Health Equity Accreditation). Many more states require organizations to coordinate or collaborate with CBOs to deliver social resources, services or interventions.

NCQA is working to build health equity requirements into its entire portfolio. Our programs are designed to guide and support each type of organization in the health care ecosystem in creating structures, processes and partnerships that illuminate health inequities, investigate their role in undoing biases and eliminating inequities and elevate health equity as an ongoing organizational priority.

NCQA's Strategy to Improve Health Equity

From Distinction to Accreditation

For over a decade, NCQA's Multicultural Health Care (MHC) Distinction gave organizations a roadmap to identify and address health care disparities for the populations they serve. Introduced in 2010, the Distinction was based on the Office of Minority Health's Culturally and Linguistically Appropriate Services (CLAS) Standards and focused on race, ethnicity and language as avenues for improving culturally and linguistically appropriate care and reducing health care disparities.

On September 30, 2021, NCQA published standards and guidelines for Health Equity Accreditation, a new program that evolved and expanded the language and activities of MHC Distinction to better reflect the role of multicultural health care as an important step toward providing equitable care.

Health Equity Accreditation

Health Equity Accreditation provides an actionable framework for developing standardized structures, processes and goals that align the entire organization in identifying opportunities to address health inequities and improve the cultural and linguistic appropriateness of care. Organizations seeking this Accreditation—including health plans, health systems, hospitals, managed behavioral healthcare organizations, population health organizations, wellness organizations and more—work to demonstrate to the individuals they serve, as well as to state regulators, payers and business partners, that they are accountable for elevating and formalizing health equity as an organizational priority.

Activities core to Health Equity Accreditation include:

- *HE 1: Organizational Readiness.* Ensuring that the organization's internal culture supports the health equity work it performs externally, beginning with the training it provides to staff and its practices for recruitment and hiring.

- *HE 2: Race/Ethnicity, Language, Gender Identity and Sexual Orientation Data*. Seeking to understand the cultural and linguistic needs of the individuals it serves by having systems and processes that collect data on race/ethnicity, preferred language, gender identity and sexual orientation.

- *HE 3*: *Access and Availability of Language Services.* Using data collected in the previous standard to inform the written and oral communications made to individuals in a way that meets their cultural and linguistic needs.

- *HE 4: Practitioner Network Cultural Responsiveness*. Maintaining a practitioner network that is capable of serving its diverse membership and is responsive to individual needs and preferences.

- *HE 5:Culturally and Linguistically Appropriate Services Programs*. Developing a program with measurable goals for continuous improvement of the cultural and linguistic appropriateness of the services the organization provides.

- *HE 6: Reducing Health Care Disparities*. Analyzing clinical performance and patient experience measures to identify disparities by race/ethnicity, preferred language, gender identity and sexual orientation, then identify and act on opportunities for improvement.

The *Standards and Guidelines for Health Equity Accreditation* are available for purchase here.

The Next Step: Health Equity Accreditation Plus

In spring 2022, NCQA will release Health Equity Accreditation Plus, a new program that builds on the activities of Health Equity Accreditation by guiding organizations in their work to establish the processes and cross-sector partnerships necessary to continuously identify and address the social risk factors of the community where they operate and the social needs of the individuals they serve. Organizations seeking this Accreditation will put structures in place that support leadership and staff in making an ongoing commitment to addressing social risks and needs, in collaboration with other organizations that share their goals.

This program is voluntary. Organizations must earn Health Equity Accreditation as a prerequisite but may pursue both programs simultaneously. Organizations that meet the requirements of Health Equity Accreditation Plus will earn a separate Accreditation status—but the work described in Health Equity Accreditation Plus is not intended to be performed separately from the foundational work in Health Equity Accreditation. Rather, this program layers new activities that enrich the organization's understanding of individuals' intersectional characteristics, identities and needs. Organizations will identify subpopulations that share intersectional characteristics and identities, as well as specific social risks or social needs, and will have the context to target interventions that account for and respect individuals' multifaceted lived experiences. By understanding the unique needs of individuals in the context of their community, organizations are better positioned to understand their role in working to improve health equity.

This public comment period seeks feedback on NCQA's draft standards for Health Equity Accreditation Plus. Refer to *Appendix 1* for the full set of draft standards.

Stakeholders Participating in Public Comment

NCQA shares these changes for public comment to generate thoughtful commentary and constructive suggestions from interested parties. Many comments lead to changes in our standards and policies, and the review process makes our standards stronger for all stakeholders.

NCQA encourages all types of stakeholders to participate in this public comment period. Health Equity Accreditation Plus will be open to the same types of organizations that are eligible for its prerequisite, Health Equity Accreditation, and NCQA recognizes that many other stakeholders—from patients, to community health workers, to CBOs, to state regulators and local government agencies—will be partners in or recipients of the important work these organizations undertake.

NCQA hopes that a variety of stakeholders will share thoughtful commentary and constructive suggestions that will make the standards for this program stronger and more meaningful for the individuals and communities that these programs are meant to benefit. NCQA asks respondents to consider whether proposed requirements are feasible as written and are clearly articulated, and to highlight areas that are not.

Health Equity Accreditation Plus: Overview of Standards

Global Questions

As you review the standards referenced in *Appendix 1*, NCQA asks that you consider the following global questions about the Health Equity Accreditation Plus program, its organization and its focus:

1. Do the order and organization of the standard categories follow a natural progression of activities?

2. Is the overarching relationship of the program's three primary focuses clear (social risk factors of the community, social needs of individuals served, roles of cross-sector partnerships)?

3. Are there activities included in this program that do not add value or are inappropriate for certain types of organizations (or in general)?

4. Will any proposed activities or language used in the standards perpetuate or exacerbate health inequities?

5. Will proposed updates help your organization meet its objectives? If so, how? If not, why not?

6. Are key expectations not addressed in the proposed requirements?

Health Equity Accreditation Plus Standards Categories and Elements

HE Plus 1: Program to Improve Social Risks and Address Social Needs

Individuals experience significant inequities in health outcomes and life expectancy based on their intersectional demographic characteristics or identities (e.g., race/ethnicity, preferred language, gender identity, sexual orientation) and the social risks of their community environment. Social risk factors are specific, adverse social conditions (e.g., social isolation, housing instability, poverty) that are associated with poor health outcomes. A community's social risks may be exacerbated by structural factors such as policies on economics, housing, education and transportation, when or if the foundations of those structures are affected by racism, classism, sexism and other biases that perpetuate inequities.

Social needs are the nonclinical needs individuals identify as essential to their well-being. An individual's social needs are related to the social risks they experience and their intersectional identities for characteristics such as race/ethnicity, preferred language, gender identity, sexual orientation and disability or mobility status; two individuals who experience the same social risks may have different social needs.

Improving these health inequities, and the underlying inequitable social conditions they reflect, requires that organizations engage the communities in which they operate and the individuals they serve to understand the community's social risks and individuals' specific social needs and identity the most impactful ways to address them. In this standard, the organization annually defines the structure, processes and goals of its program to identify and address social risks and social needs, building on its culturally and linguistically appropriate services (CLAS) program in Health Equity Accreditation.[3,4,5,6]

Elements include:

A: Program Description.

The organization has a written program description for addressing social risks and needs that specifies its processes and work plan for the activities performed in standards HE Plus 2 (Collection and Analysis of Community and Individual Data), HE Plus 3 (Cross-Sector Partnerships and Engagement) and HE Plus 5 (Referrals, Outcomes and Impact). These activities also inform updates to the program's prioritized activities and work plan to ensure that the program reflects the needs that are important to and impactful for members of the community and the individuals the organization serves.

B: Annual Work Plan.

The organization maintains an annual work plan for its program that outlines the activities in which it will engage and the resources or interventions it will provide to meet the program's goals.

C: Program Evaluation.

The organization evaluates its program based on the performance of its program goals and feedback from stakeholders, including the community and individuals served.

Targeted Questions for HE Plus 1

- Do you support adding new element HE Plus 1A: Program Description?
- Should the processes described in HE Plus 1A, factors 4–10 be performed annually?
- What are good ways to demonstrate that the program's objectives support diversity, equity, inclusion and cultural humility for HE Plus 1A, factor 11?
- What are the parameters of a "community" for organizations like health plans with broad service areas as large as a state or geographical region? (e.g., provider network, county, neighborhood)
- Do you support adding new element HE Plus 1B: Annual Work Plan?
- Do you support adding new element HE Plus 1C: Program Evaluation?

HE Plus 2: Collection and Analysis of Community and Individual Data

Organizations must look at data beyond health records to understand the conditions that created individuals' health outcomes and social needs, including the social risks they experience as members of their community and as individuals with specific intersectional characteristics and identities. Understanding is crucial to the success or failure of the program's strategy to address social risks and needs.

Data from multiple sources, from key informant interviews[7] to regional statistics, gives organizations valuable context about the lived experiences of the individuals they serve and informs the activities they prioritize for the program, the social resources or interventions they make available for individuals and the partners with whom they seek to collaborate. In this standard, the organization collects or integrates community and individual-level data to understand the social risks of the community where it operates and the needs of the individuals it serves.[8]

Elements include:

A: Community-Level Social Risk Data Integration.

The organization has a framework for integrating community-level social needs data every 3 years from at least three different sources, reducing risk that analysis will draw biased or misleading conclusions.

B: Collection of Individual-Level Social Needs Data.

The organization has a framework for direct collection of individual-level data for a list of social needs that include financial security, housing stability, access to transportation, interpersonal safety, access and barriers to health care. The organization identifies the individuals from whom it collects data on social needs; it is not required to collect data for the entire member population. This element does not prescribe the methodology to collect data, but direct collection may include information collected directly from an individual by the organization as well as by partners or third-party sources.

C: Identification of Individual Social Needs Resources.

The organization has a process for using the individual-level data it collected to identify the most appropriate resources for individuals.

D: Population Segmentation or Risk Stratification.

The organization has a process to use the community- and individual-level data it collected to identify subpopulations of individuals in the community and the population it serves who share specific intersectional identities (e.g., a subpopulation of individuals sharing a racial/ethnic and sexual orientation identity),experience specific social risks or have specific social needs.

E: Analysis of Community-Level and Individual-Level Data.

The organization analyzes its community- and individual-level data and subpopulations to understand similarities and differences between the social risks and needs identified by each type of data and draws conclusions to inform the prioritization of its work plan activities and program goals (i.e., the program's focus).

Targeted Questions for HE Plus 2

- Do you support adding new element HE Plus 2A: Community-Level Social Risk Data Integration?
- Do you support adding new element HE Plus 2B: Collection of Individual-Level Social Needs Data?
- Should the minimum list of social needs in HE Plus 2B, factors 1–7, include Adverse Childhood Experiences (ACEs)?
- Do you support adding new element HE Plus 2C: Identification of Individual Social Needs Resources?
- Should the process described in HE Plus 2C require organizations to outline appropriate timeframes for referring individuals to resources or interventions?
- Do you support adding new element HE Plus 2D: Population Segmentation or Risk Stratification?
- Should the activity described in HE Plus 2D be performed annually?
- Do you support adding new element HE Plus 2E: Analysis of Community-Level and Individual-Level Data?
- Should the activity described in HE Plus 2E be performed annually?

HE Plus 3: Cross-Sector Partnerships and Engagement

No organization, industry or sector possess the resources, expertise and community trust to move the needle on health equity alone. Engaging in cross-sector partnerships is a way to use the strengths, knowledge and capabilities of organizations that represent different sectors or disciplines for collaborative efforts to deliver social resources or interventions that address individuals' needs and support their optimal health, as well as to collectively address social conditions and risks that impact the broader community.

In this standard, the organization engages with a variety of stakeholders—including, but not limited to, public health agencies, health care systems or providers, health plans, local social service or CBOs, government entities, community members and individuals served—in mutually beneficial, equitable and supportive partnerships that collaborate to address the social risks of the communities and social needs of individuals that they mutually serve.[9,10,11]

Elements include:

A: Selection of Appropriate Cross-Sector Partners.

The organization's process for selecting appropriate partner organizations is based on the social risks and needs identified in HE Plus 2 (Collection and Analysis of Community and Individual Data), the program's work plan and goals (HE Plus 1, Elements A: Program Description and B: Annual Work Plan), the cultural and linguistic characteristics of the individuals it serves who were identified in Health Equity Accreditation (HE 2, Elements A–E) and a gap analysis of the organization's capacity and capabilities to address identified risks and needs (HE Plus 1, Element A).

B: Equitable Partnership Agreements.

The organization's written contracts or agreements with partners with which it collaborates to address individuals' social needs clearly and transparently describe the roles and responsibilities of each partner, with attention to the mutual benefit of the partnership, and how the partnership will be evaluated to support quality improvement.

C: Collaboration with Cross-Sector Partners.

The organization has a process for collaborating with organizations it identifies as appropriate in HE Plus 3, Element A, to provide social resources or interventions, create and annually maintain a shared community resource directory and document, maintain and support community-based initiatives.

D: Equitable Community Engagement.

The organization establishes at least one advisory function to inform the program by equitably engaging members of the community to gather input about how well the program meets the community's needs.

E: Equitable Consumer Engagement.

The organization establishes at least one advisory function to inform the program by equitably engaging individuals from the population it serves.

Targeted Questions for HE Plus 3

- Do you support adding new element HE Plus 3A: Selection of Appropriate Cross-Sector Partners?
- Do you support adding new element HE Plus 3B: Equitable Partnership Agreements?
- Do you support adding new element HE Plus 3C: Collaboration with Cross-Sector Partners?
- Do you support adding new element HE Plus 3D: Equitable Community Engagement?
- Do you support adding new element HE Plus 3E: Equitable Consumer Engagement?
- HE Plus 3D and 3E require demonstration of the process to involve community members/individuals served, HE Plus 1A (factor 6). Is this a necessary layer of accountability (support) or duplicative (do not support)?
- What potentially negative consequences may result from allowing use of third-party community resource directories for HE Plus 3C, factor 2, in lieu of requiring them to create their own?

HE Plus 4: Data Management and Interoperability

Collaboration among organizations in a partnership requires a shared understanding of the social risks and needs of the individuals and communities they mutually serve. Each partner may have differing abilities to collect data (e.g., level of detail, how current it is) on individuals and/or the community, and sharing this information offers an opportunity to draw more nuanced and actionable insights to inform shared goals and initiatives. Creating pathways that share data in the right format, through the right channel and at the right time, while protecting patient privacy, also lowers the administrative burden on organizations collecting data, and lowers the human burden on individuals providing it.[12,13,14,15,16,17]

In this standard, the organization puts in place data privacy and security processes to support interoperability between partners and protect the security and privacy of individuals' social needs and risks data.

Elements include:

A: Privacy and Security Protections for Data.

The organization describes its controls for physical and electronic access to data, privacy and security protocols for sharing data and permissible vs. impermissible use of data.

B: Data Sharing.

The organization has a data sharing strategy that includes processes for sharing individuals' demographic and social needs data with established partners (HE Plus 3, Element B) and with partners with which it has no written agreement.

C: Notification of Privacy, Security and Sharing Policies.

The organization communicates information to the individuals it serves about its controls for physical and electronic access to data, privacy and security protocols for sharing data, permissible and impermissible use of data and how the organization communicates to individuals how they may opt out of sharing data.

Targeted Questions for HE Plus 4

- Do you support adding new element HE Plus 4A: Privacy and Security Protections for Data?
- Do you support adding new element HE Plus 4B: Data Sharing?
- Should organizations share data with partners with whom they have no written agreement or contract?
- Do you support adding new element HE Plus 4C: Notification of Privacy, Security and Sharing Policies?
- Does the communication in HE Plus 4C adequately meet the intent of giving individuals enough information to make a voluntary and informed choice to allow data to be shared/used?

HE Plus 5: Referrals, Outcomes and Impact

When making referrals, organizations should have mechanisms in place to ensure that individuals are connected to social resources or interventions that they agree are important, consent to receive and are provided through partners that are best-suited to provide not only the resource or intervention, but to provide resources and interventions that are appropriate for the individual's specific needs (e.g., demographic characteristics, disability status). Tracking referrals, identifying disparities between subpopulations and evaluating the effectiveness of its partnerships are ways to ensure that the organization has the opportunity to improve its referral processes and the partnerships that support it.

Elements include:

A: Facilitating Referrals.

The organization has a process for referring individuals to partner organizations that includes confirming individuals agree that the identified social need is a priority and consent to the referral, as well as communicating minimum expectations for the organization, its partners and the individual during the referral process.

B: Tracking Referral Status.

The organization demonstrates that it collaborates with its partner organizations to confirm that a referral request was received and the individual received or accessed the referred service.

C: Assessing Referral Status for Disparities.

The organization annually analyzes the referral statuses tracked in HE Plus 5, Element B to identify if disparities exist by race/ethnicity, preferred language, gender identity and/or sexual orientation.

D: Bidirectional Partnership Process Assessment.

Every 3 years, the organization and its partners collaborate to evaluate their partnership based on individuals' experience accessing or receiving social resources and interventions, the individuals' experience with discrimination or racism, the completion rate and outcomes of referrals and feedback from both partner organizations about the partnership process.

> ## Targeted Questions for HE Plus 5
>
> - Do you support adding new element HE Plus 5A: Facilitating Referrals?
> - Do you support adding new element HE Plus 5B: Tracking Referral Status?
> - Should HE Plus 5B track referral "status," "progress," "completion" or something else?
> - Do you support adding new element HE Plus 5C: Assessing Referral Status for Disparities?
> - Do you support adding new element HE Plus 5D: Bidirectional Partnership Process Assessment?
> - Is an annual frequency to evaluate the effectiveness and appropriateness of partnerships (HE 5C) too burdensome?

Additional Questions

Evaluating Bias in Algorithms

In addition to the standards proposed for public comment, NCQA is exploring requirements for evaluating whether algorithms that support processes (e.g., stratification/segmentation, prior authorization, utilization management, clinical decision making and social needs resource allocation) create or perpetuate bias.

> ## Targeted Questions About Evaluating Bias in Algorithms
>
> - For which processes does your organization currently use algorithms (e.g., social needs resource allocation, prior authorization, UM, clinical decision-making)?
> - How does your organization assess the data source(s) that inform your algorithms?
> - How does your organization evaluate whether your algorithm is working as intended?
> - Are the algorithms used by your organization purchased or developed in-house?
> - If an organization discontinues use of an algorithm after bias has been identified, is the risk of replacing it with a potentially more biased human decision maker greater than the harm caused by the algorithm?

Public Comment Instructions

Documents

Draft standards for Health Equity Accreditation Plus may be referenced in *Appendix 1: Standards Proposed for Health Equity Accreditation Plus*.

How to Submit Comments

Respond to topic and element-specific questions for each product on NCQA's public comment website. NCQA does not accept comments by mail, email or fax.

1. Go to http://my.ncqa.org and enter your email address and password.
2. Once logged in, scroll down and click **Public Comments**.
3. Click **Add Comment** to open the comment box.
4. Select **Health Equity Accreditation Plus Proposed Standards** from the drop-down box.
5. Click to select one or more of the following **Topics** from the drop-down box:
   - **HE Plus 1: Program to Evaluate Social Risks and Address Social Needs.**
   - **HE Plus 2: Collection and Analysis of Community and Individual Data.**
   - **HE Plus 3: Cross-Sector Partnerships and Engagement.**
   - **HE Plus 4: Data Management and Interoperability.**
   - **HE Plus 5: Referrals, Outcomes and Impact.**
6. Click to select the **Element** (question) on which you would like to comment.
7. Click to select your support option (**Support, Do not support, Support with modifications**).
   a. If you choose **Do not support**, include your rationale in the text box.
   b. If you choose **Support with modifications**, enter the suggested modification in the text box.
8. Enter your comments in the **Comments** box.
   Note: There is a 2,500-character limit for each comment. We suggest developing comments in Word to check your character limit; use the "cut and paste" function to copy into the Comments box.
9. Use the **Submit** button to submit more than one comment. Use the **Close** button to finish leaving comments; you can view all submitted comments in the **Public Comments** module.

<p style="text-align:center;color:red;">All comments must be entered by December 17 at 11:59 p.m. ET</p>

Next Steps

The final Standards and Guidelines for Health Equity Accreditation Plus will be released in spring 2022, following approval by the NCQA Standards Committee and the Board of Directors.

Requirements will take effect for surveys on or after July 1, 2022. Organizations coming forward for Accreditation after this date must meet the new requirements.

Additional Information

NCQA's Specialty Advisory Committee

Health Equity Accreditation Plus is being developed under the ongoing guidance of a special advisory committee of experts who represent diverse backgrounds, geographies and health care perspectives, from health plans to state agencies, CBOs and the medical delivery system. The committee was convened through the sponsorship and support of The California Endowment. Its members are listed below.

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