Integrated Care Resource Center

TECHNICAL ASSISTANCE TOOL

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Implications of Health Homes for NCQA Health Plan Accreditation

IN BRIEF: Many state Medicaid programs are pursuing the new state plan option to create health homes for eligible beneficiaries. Some states are developing health homes within a managed care model, with varying roles for health plans in the management and delivery of health home services.

This technical assistance tool from the *Integrated Care Resource Center* provides guidance on considerations related to National Committee for Quality Assurance (NCQA) health plan accreditation, particularly when non-health plan entities are designated as health home providers and health home services are provided outside of the health plans. NCQA reviewed and confirmed the considerations outlined in this document.

State Medicaid programs across the country are advancing new health home programs for eligible beneficiaries, as authorized under Section 2703 of the Affordable Care Act. In some states, these initiatives are being designed for implementation within managed care delivery systems, with varying roles for Medicaid health plans in the delivery and management of health home services. Depending on how states structure their health home models, health plans may have responsibility for directly providing health home services; however, a more common approach to date has been for states to define non-health plan entities as health home providers (such as community mental health centers, primary care providers, or consortia of community-based providers). In this latter case, when the state designates primary care or other community-based providers to deliver health home services, the health plan may still be accountable for the management and oversight of health home services according to National Committee for Quality Assurance (NCQA) accreditation standards. This technical assistance tool, which was developed by the *Integrated Care Resource Center* (ICRC) and reviewed by NCQA, seeks to provide guidance to "health home states" and their health plan partners on these issues related to NCQA accreditation.

NCQA Standards at Issue

The specific NCQA health plan accreditation standards at issue include complex case management (QI 7) and disease management (QI 8) requirements, as well as the NCQA standard for delegation and oversight when these activities are performed by providers outside of the health plan (QI 12).[1,2] Scoring for QI 7 and QI 8 involve the elements listed in Table 1, which include case reviews for selected elements. QI 12 requirements vary depending on whether the "delegated" provider is NCQA-recognized. These requirements are summarized in Table 2. In all cases except where state-approved health home providers are also NCQA-recognized Patient-Centered Medical Homes (PCMHs), the third column of the table ("Delegation to Practice Not Recognized by NCQA") is most relevant to the health home discussion.

Requirements for Plans Delegating Health Home Services to Non-NCQA Recognized Providers

In reviewing this document, NCQA has confirmed the following requirements for health plan accreditation when health home services are provided by non-NCQA recognized providers:

- **Written delegation agreements are <u>not</u> required** provided that the state has approved the delegated entity as a health home provider in accordance with state-documented standards for health home service delivery,

and that the state has documented performance expectations for both the delegated providers and the health plan regarding health home service delivery.

- **A pre-delegation evaluation is required**, which must include a review by the health plan of each health home's capabilities for performing case management and/or disease management functions.

- **An annual file audit is required**, which must use one of the following methods: lesser of five percent or 50 files, or the NCQA "8/30 methodology" to review denial and appeal files.[3]

- **An annual evaluation is required**, which must include an annual review by the health plan of each health home's performance against NCQA standards. Health plans are also required to act on opportunities for improvement identified in these reviews.

- **At least twice per year, plans must receive reports from health homes** related to delegated activities.

Implications for NCQA Scoring

Scoring for NCQA health plan accreditation as of 2012 is based on two main components: performance against Health Plan Standards and performance against Healthcare Effectiveness Data and Information Set and Consumer Assessment of Healthcare Providers and Systems measure benchmarks and thresholds. In considering the implications of health homes design for health plans, States should be aware of the following considerations related to the delegation issues discussed in this brief:

- **The number of points at issue here are relatively small.** With delegation, the elements at issue across QI 7, QI 8 and QI 12 are worth 5.18 out of 100 total points, with a small subset of these points related to the file review elements.

- **The scoring process is not business line-specific**. To the extent a health plan operates both a commercial and Medicaid plan in the same state, its NCQA accreditation status (and associated scoring) is tied to the plan's performance across all insurance products.

- **Partial scoring is available.** For each standard, health plans can earn partial credit for factors met.

- **Accreditation status is maintained for three years.** The implications for implementing a new health home program may vary on a plan-by-plan basis depending on the timing of their next NCQA survey.

Additional Considerations

- NCQA will give a one-year exemption on file review (QI 7 F and G) if plans can show that patients received these services from a health home paid by the state. The file review exception is based on the start date of a health home in the state program. Plans must include the health home's start date in file review documentation reviewed during the NCQA survey process. During this review, deficiencies will be documented in the Survey Tool but scored "NA" during the exemption period, and fully-met factors will be scored 100 percent.

- To the extent that a state expressly prohibits plans from performing NCQA-required functions through regulations or contracts, such functions would be excluded from the accreditation scoring process based on existing NCQA policy on conflicts with regulatory requirements. If the prohibition affects only a portion of the plan's membership, the plan must meet NCQA requirements for any other portions of its membership. Plans must present documentation identifying the prohibition when they submit their Survey Tool for accreditation.

- States should consider including health plans in the planning phase of their health home approach and allowing the plans to provide input on health home provider standards and/or selection. This may allow the plans to use this process to fulfill the capabilities assessment as required in QI 12. Additionally, as the State moves forward with the health home model, the State may want to include its health plans in health home quality oversight and monitoring, which also may provide evidence of the annual file audit and assessment requirements.
- If a State is considering using its health plans as part of the team of health home providers (e.g., the health plans will be involved in delivery of health home services), the State should consider what level of complex case management and disease management activities need to occur at the plan level to maintain their current NCQA status and may want to consider only providing additional activities included in the health home model at the practice level.

Table 1: **Required Elements of NCQA Health Plan Standards QI 7 and QI 8**
QI 7: COMPLEX CASE MANAGEMENT
Element A: Population Assessment
Element B: Identifying Members for Case Management
Element C: Access to Case Management
Element D: Case Management Systems
Element E: Case Management Process
Element F: Initial Assessment*
Element G: Case Management—Ongoing Maintenance*
Element H: Satisfaction With Case Management
Element I: Measuring Effectiveness
Element J: Action and Re-measurement
QI 8: DISEASE MANAGEMENT
Element A: Identifying Chronic Conditions
Element B: Program Content
Element C: Identifying Members for DM Programs
Element D: Frequency of Member Identification
Element E: Providing Members With Information
Element F: Interventions Based on Assessment
Element G: Eligible Member Active Participation
Element H: Informing and Educating Practitioners
Element I: Integrating Member Information
Element J: Satisfaction With Disease Management
Element K: Measuring Effectiveness

** Scoring involves case reviews.*

Table 2: How Health Plan Standard QI 12 Applies to Delegating QI 7 or QI 8 to Other Providers		
QI 12 Element:	**Delegation to PCMH Recognized by NCQA**	**Delegation to Practice Not Recognized by NCQA**
A: Written Delegation Agreement	If the organization's materials describe the organization's overall medical home approach and explain performance expectations of medical home and health plan, then individual signed agreements are not required.	If the organization's materials describe the organization's overall medical home approach and explain performance expectations of medical home and health plan, then individual signed agreements are not required.
B: Provisions for PHI	NA: All delegates are covered entities.	NA: All delegates are covered entities.
C: Approval of Program	NA because of NCQA Recognition.	NA: Assumed, based on inclusion of practice in the scope of the health home initiative.
D: Predelegation Evaluation	NA because of NCQA Recognition.	Capabilities assessment is required for all practices involved. At a minimum, this must include a review of each medical home's capabilities for performing case management and/or disease management functions.
E: Annual File Audit	NA because of NCQA Recognition.	Annual file audit must use one of the following methods: lesser of five percent or 50 files, or NCQA "8/30 methodology" to review denial and appeal delegate files.
F: Annual Evaluation	NA because of NCQA Recognition.	Annual assessment of the effectiveness of the medical home program includes assessment of practice capabilities and performance. At a minimum, this must include an annual program-wide review of practice capabilities and performance against program expectations.
G: Reporting (semiannual)	Must receive and evaluate reports from delegates at least semiannually. Reporting may be in the form of joint meetings or conferences, and may include raw data, committee meeting minutes, and/or QI activity findings.	Must receive and evaluate reports from delegates at least semiannually. Reporting may be in the form of joint meetings or conferences, and may include raw data, committee meeting minutes, and/or QI activity findings.
H: Opportunities for Improvement	NA because of NCQA Recognition.	Required to act on opportunities identified in the program's annual evaluation.

ABOUT THE INTEGRATED CARE RESOURCE CENTER

The ***Integrated Care Resource Center*** is a national initiative of the Centers for Medicare & Medicaid Services to help states improve the quality and cost-effectiveness of care for Medicaid's high-need, high-cost beneficiaries. The state technical assistance activities provided within the ***Integrated Care Resource Center*** are coordinated by Mathematica Policy Research and the Center for Health Care Strategies. For more information, visit **www.integratedcareresourcecenter.com.**

Endnotes

[1] National Committee for Quality Assurance. "2012 Standards and Guidelines for the Accreditation of Health Plans." 2011.
[2] National Committee for Quality Assurance. "Revision to NCQA Policy on Delegating Functions to Patient-Centered Medical Homes (PCMH) of November 15, 2011." May 9,2012
[3] The 8/30 methodology involves review of an initial sample of eight files, followed by review of an additional sample of 22 files if any of the original eight fails the review (for a total of 30 records). For more information, see http://www.ncqa.org/updates.