HMA

HEALTH MANAGEMENT ASSOCIATES

National Accreditation Bodies and Fit for Covered California

PREPARED FOR COVERED CALIFORNIA

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Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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Executive Summary

Background

Covered California's mission is to increase insurance coverage in California and improve quality of care while reducing costs and health disparities. Attachment 7 of the Qualified Health Plan (QHP) Issuer Individual Market Model Contract (Quality, Network Management, Delivery System Standards and Improvement Strategy) lays out Issuer requirements and is designed to hold Issuers accountable for quality care and delivery reform. The guiding principles that underlie Attachment 7 express the goal of assuring effectively delivered quality care and improving population health in ways that are thoughtfully measured, appropriately aligned with other purchasers, promote access to strong provider networks and consumer tools and support, align payment with value, and minimize variation in care.

Covered California engaged Health Management Associates (HMA) to evaluate accreditation requirements and processes of the National Committee for Quality Assurance (NCQA), URAC, and the Accreditation Association for Ambulatory Health Care (AAAHC).[1] HMA was asked to recommend which accreditation body's requirements and process aligns best with Covered California's expectations, including through an assessment of the extent to which accreditation focuses on core health plan competencies (for example, utilization management, chronic disease and complex care management, and grievances and appeals).

Methodology

HMA reviewed the accreditation bodies' structures, requirements and processes in order to assess their organization, methodology, the topics they evaluate, and the documentation they collect. We evaluated the rigor of each body's process and documentation requirements, including the extent to which they review health plan performance measurement. We identified elements considered critical to accreditation and assessed each accreditation body's market reach and any third-party endorsements.

Recommendations

NCQA Supports Covered California's Strategic Goals

While each accrediting body has its own strengths, ***NCQA is the best fit for Covered California's goals of achieving health plan quality and ensuring rigor in core areas of health plan control.*** AAAHC has limited standards in utilization management and disease management, lacks rigor in some assessed areas, and fails to conduct file review for Case Management and Utilization Management. While URAC standards take a unique modular approach and it is strong in its assessment of internal plan workings, URAC lacks complex care management standards, an area of particular interest to Covered California. NCQA requires more rigorous documentation in its assessment of compliance with standards.

NCQA accreditation standards and scoring rely heavily on demonstrated quality outcomes and utilize HEDIS and CAHPS. NCQA accreditation standards include a Population Health Management domain, which is unique to NCQA and requires a systematic approach to develop a population health strategy, program, member and delivery systems supports, and impact evaluation.

Requiring all Covered California QHPs achieve NCQA accreditation will be minimally disruptive as NCQA is already the accreditation body for all but two Issuers participating in Covered California. Should Medi-Cal follow up on its consideration of requiring NCQA accreditation, Covered California could further increase cross-market alignment by implementing the same requirement.

[1] The acronym URAC originally stood for Utilization Review Accreditation Commission. The organization officially shortened its name to URAC in 1996 when it began accrediting health plans, pharmacies, and provider entities.

Accreditation Can be Used to Assess Compliance with Core Health Plan Functions

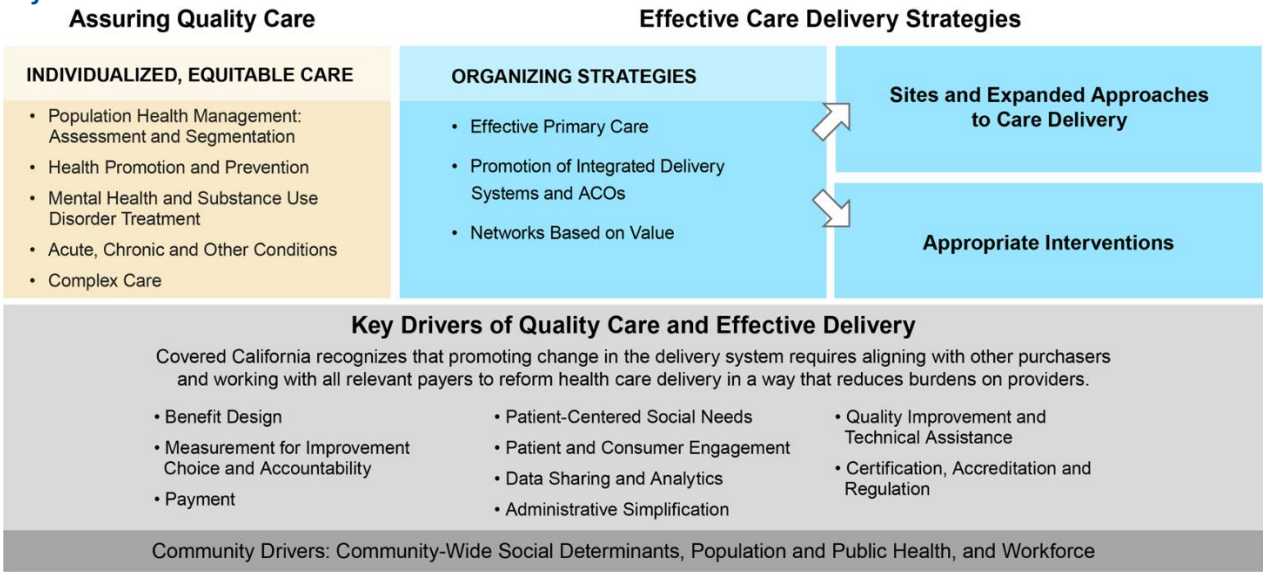
Accreditation predominantly focuses on commonly accepted processes, measures, and goals for health plan operations and quality. NCQA accreditation will provide Covered California with assurance that the Issuer is compliant with health plan principles and business functions. We recommend that Covered California request final audit reports from accreditation.

Background

Promoting Quality and Value: Covered California's Contract "Attachment 7"

Covered California's mission is to increase insurance coverage in California and improve quality of care while reducing costs and health disparities. Covered California has developed a framework for holding plans accountable for quality care and delivery reform, which is expressed in the graphic below and operationalized through its contract with its Qualified Health Plan (QHP) Issuers.

Figure 1. Covered California's Framework for Holding Plans Accountable for Quality Care and Delivery Reform[2]



The contract explicitly recognizes the Issuers' role in promoting quality and value. Attachment 7 of the QHP Issuer Individual Market Model Contract (Quality, Network Management, Delivery System Standards and Improvement Strategy) lays out Issuer requirements that include management of QHP members and efforts to improve the delivery system as a whole. In addition to addressing traditional Issuer requirements, Attachment 7 is designed to hold Issuers accountable for quality care and delivery reform. Those expectations evolve over time in order to improve quality of care and reform the delivery system based on the best evidence available at the time.

In 2019, Covered California began a deliberative process with stakeholders through which it is updating the 2022 contract year Attachment 7 requirements based on a set of guiding principles for developing the Marketplace's expectations for Issuers, updated in August 2020:

1. Contract expectations are driven by the desire to meet three complementary and overlapping objectives:
    - Assuring Quality Care: Ensuring our enrollees receive the right care, at the right time, in the right setting, at the right price.
    - Effective Care Delivery: Promoting value-enhancing strategies that have the potential to reform the delivery system in the near- and long-term.

[2] Covered California, Attachment 7 Framework, January 2019.

- Promoting Health Equity: Improving the health of the population by acknowledging the role of social determinants and systemic racism and working with issuers and partners to address the impact of social needs and health disparities experienced by its enrollees.

2. Success will be assessed by outcomes, measured at the most appropriate level, in preference to adoption of specific strategies.
3. Prioritizing requirements that meet multiple objectives and leveraging existing initiatives and mechanisms will reduce administrative burden.
4. Promoting alignment with other purchasers will maximize impact, elevate shared priority objectives and increase efficiency.
5. Enrollees will have access to networks offered through the issuers that are based on high quality and efficient providers.
6. Enrollees will have the tools needed to be active consumers, including tools for provider selection and shared clinical decision making.
7. Payment will increasingly be aligned with value and proven delivery models.
8. Actively monitor and reduce variations in quality and cost of care to ensure better outcomes across the network for all Covered California Enrollees.

Consistent with its desire to hold Issuers accountable, Covered California asked Health Management Associates (HMA) to identify which of the three national accreditation bodies approved to accredit QHPs (National Committee for Quality Assurance [NCQA], URAC, and the Accreditation Association for Ambulatory Health Care [AAAHC]) has requirements and process that align best with Covered California's expectations of core health plan competencies in delivering quality care as the foundation of this accountability.[3, 4]

The Marketplace was particularly interested in a review and assessment of how the accreditation bodies require Utilization Management, appeals and grievances, and chronic disease and complex care management (previously categorized as disease management) as threshold competencies for accreditation. Covered California values standardized measurement and audit in addition to review of documentation of policies, procedures and processes. Attachment 7 does not specifically address all of these core health plan functions, as accreditation is required for participating Issuers. HMA also assessed the extent to which each accreditation approach aligns with requirements in Attachment 7 that promote a reformed delivery system.

Methodology

Review of Covered California Attachment 7

In preparation for analyzing the three accreditation bodies' requirements and processes, HMA reviewed Attachment 7 of the Covered California contract in the context of the organization's report *Holding Health Plans Accountable for Quality and Delivery System Reform*. As requested by Covered California, we focused on Health Equity, Quality Improvement, Network Performance, and Delivery System Reform.

[3] As noted in the Executive Summary, the acronym URAC originally stood for Utilization Review Accreditation Commission. The organization officially shortened its name to URAC in 1996 when it began accrediting health plans, pharmacies, and provider entities.

[4] HMA also investigated whether a requirement that all Marketplace Issuers earn NCQA Distinction in Multicultural Health Care would help Covered California increase equity and inclusion in QHP offerings. Analysis on this topic was provided to Covered California in a separate companion report.

Accreditation Bodies' Structure, Content and Process

We reviewed survey materials, instructions and other materials from the three accreditation bodies in order to identify how they are organized, their accreditation review methodology, the topics they evaluate, and types of documentation collected. HMA reviewed accreditation bodies' documentation of the process used by each, noting key data, activities, and reports that Issuers must provide to the accreditation body in order to identify whether any of these documents could be provided to Covered California as evidence the QHP is meeting Marketplace requirements. Such documents could be provided as part of the Covered California-Issuer contract process, to help Covered California increase its understanding of QHP performance or to replace current Attachment 7 requirements. We specifically focused on how each accreditation body handles its review of the core health plan functions utilization management, chronic disease and complex care management (previously categorized as disease management), and grievances and appeals. In addition, we identified the elements each accreditation body considers a "critical factor" or "must pass" element, for which the Issuer must have a passing score on the standard to gain accreditation.

Accreditation Review in Key Areas of Interest to Covered California

We evaluated the accreditation bodies on the rigor with which they assess health plan performance and the extent to which they review health plan performance measurement. This assessment was conducted for each of the Attachment 7 articles:

- Reducing Health Disparities and Ensuring Health Equity
- Promoting Development and Use of Effective Care Models
- Hospital Quality
- Population Health: Preventive Health, Wellness and At-Risk Enrollee Support
- Patient-Centered Information and Support
- Payment Incentives to Promote Higher Value Care

We also identified the level of alignment with the articles. We then assessed whether one or more of the contractual and operational requirements are sufficiently aligned with an Attachment 7 element that accreditation can serve as a mechanism to enhance accountability for health plans across the articles of attachment 7 and core health plan functions.

Accreditation Bodies' Market Reach and Endorsements

We collected lists of the Issuers accredited by each accreditation body, including Issuers offering QHPs in California and elsewhere. We reviewed Quality Rating System (QRS) scores for Issuers accredited by each organization.[5] The overall QRS score is a roll-up that includes scores for member experience, medical care, and health plan administration. We also identified states and federal agency endorsements of each accreditation body.

Develop Findings

To develop findings, we assessed how each accreditation entity approaches key health plan tasks such as utilization management, chronic disease and complex care management (previously categorized as disease management), and appeals/grievances; how accreditation body requirements align with the elements in each Attachment 7 article; the requirements' level of rigor (including the use of outcomes measures where appropriate); and the use of "must pass" elements in key areas.

[5] As of 2020, QRS ratings are shown on all Marketplace sites reviewed, other than Your Health Idaho.

Findings

Each accrediting body assesses Issuer compliance with core functions including utilization management, chronic disease and complex care management (previously categorized as disease management) and appeals and grievances. The rigor of documentation, use of performance measures, and whether plans can fail a standard and still achieve accreditation vary by accrediting body and standard.

Our review of core health plan functions (utilization management, chronic disease and complex care management (previously categorized as disease management) and appeals/ grievances) highlights where each accreditation body focuses and the relative comprehensiveness of the three entities. ***Overall, NCQA is the most comprehensive in terms of standards and requirements for these core health plan functions.***

A. Accreditation Structure

There is significant overlap in accreditation bodies standards, particularly in QHP-specific areas as each has been approved by CMS to accredit QHPs. However, each accreditation body has its own way of organizing Issuer accreditation and its own scoring methodology, both of which are associated with its organizing philosophy or guiding concepts.

AAAHC. As the name implies, AAAHC initially focused on ambulatory health care organizations.[6] The organization promotes a peer-based, consultative, and educational process. The accreditation survey process is seen as a way to evaluate an Issuer's compliance with standards and an opportunity to play an educational and consulting role with the health plan. While AAAHC has accredited Issuers since 1983, it overhauled its standards in 2012 to increase the organization's focus on managed care principles.

The AAAHC pre-onsite process includes completion of an application and a public notice of the accreditation survey. The onsite process includes observation of processes, staff interviews, document review, and file review. All Issuers seeking AAAHC accreditation are assessed on standards in 10 areas, while QHPs are also assessed on performance measures applying only to them:

- Member Rights, Responsibilities, and Protections
- Governance
- Administration
- Provider Network Credentialing
- Network Adequacy
- Case Management and Care Coordination
- Health Education and Wellness Promotion
- Clinical Records and Other Health Information
- Environment of Care and Safety
- Quality Improvement and Management (includes Quality Improvement Program, Utilization Management, and Risk Management
- (QHPs only) Performance Measures Attestation, QRS results and Enrollee Satisfaction Survey results

NCQA. The NCQA mission is to improve the quality of health care and sees itself as measuring health plan quality as a way to improve health care. As expressed in its materials, NCQA is explicitly data focused and assesses how well health plans promote the provision of evidence-based care. While the

[6] AAAHC was founded by the American College Health Association, American Group Practice Association (now American Medical Group Association), Federated Ambulatory Surgery Association (now Ambulatory Surgery Foundation), Group Health Association of America (now American Association of Health Plans), Medical Group Management Association, and National Association of Community Health Centers.

Issuer is accredited as an entity, it must separately submit Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) results each of its product lines (which depending on the Issuer will be some or all of the following: commercial; Exchange; Medicaid; and Medicare). Data from the Exchange product line is reported separately and included in the commercial product line data. In addition, NCQA looks for organizational functioning that supports good care for consumers.

The survey process consists of an offsite review of documents and an onsite file review. This is followed by calculation of the Issuer's rating based on the its scores on standards, HEDIS, and CAHPS. NCQA accreditation standards cover six domains:

- Quality Management and Improvement
- Population Health Management
- Network Management
- Utilization Management
- Credentialing and Recredentialing
- Member Experience

Issuers can opt into assessment in additional domains that apply to products and covered benefits in: Long-Term Services and Supports; Medicaid; Medicare Advantage; and Special Needs Plans.

URAC. As an organization, URAC centers patients and providers by promoting local solutions and performance measurement. URAC historically accredited managed care organizations and therefore focused on managed care organizations' core activities. Accordingly, accreditation reviews an Issuer's operations, quality of care and consumer protection.

The URAC survey process includes application, document review, an onsite survey, and ongoing monitoring. Monitoring includes the submission of quality measures to URAC. URAC core standards cover the following 13 areas:

- Organizational Structure
- Policies and Procedures
- Regulatory Compliance
- Inter-Departmental Coordination
- Marketing and Sales Communications
- Business Relationships
- Information Management
- Quality Management
- Staff Qualifications
- Staff Management
- Clinical Staff Credentialing and Oversight Role
- Health Care System Coordination
- Consumer Protection and Empowerment

URAC accreditation utilizes these core standards, which are augmented by additional modules that are aligned with organizational functions and designed to meet business goals. Issuers are audited based on core standards and one or more modules. Modules include:

- Health Insurance Marketplace
- Network Management
- Credentialing
- Member Relations

- Quality Management
- Health Plan Operations
- Compliance Program
- Mental Health Parity
- Health Utilization Management
- Measures Reporting

In addition to accrediting about 10 percent of health plan Issuers in the United States, URAC has become a leader in Pharmacy Benefit Manager (PBM) accreditation, having accredited PBMs that process 95 percent of all commercial prescription claims in the US, along with 500 specialty pharmacies.

B. Content and Process

Topics Evaluated

Accreditation standards are aligned with core business functions and common regulatory requirements for health plans. Each accrediting body evaluates standards for:

- Quality management and improvement
- Continuity and coordination of care
- Credentialing and recredentialing
- Utilization management
- Appeals and grievances
- Member experience
- Health education and wellness
- Case management and care coordination
- Provider network management
- Access and availability
- Pharmacy services
- Delegation oversight

While some of these standards align with elements in Attachment 7, accreditation standards are focused on basic regulatory and contractual requirements. Innovation and enhancements specified in Attachment 7 are largely missing from accreditation requirements. URAC does include leading indicators that represent optional practices that are not yet widely accepted in health care.

Documentation Types

Accrediting bodies use a variety of documentation to determine if health plans meet standards, including:

Documented Process: evidence of procedures, which may include:

- Policies and procedures
- Workflows
- Program documents such as Quality Improvement Program Description or Compliance Program documents

Materials: qualitative proof of implementation, such as:

- Member materials: member newsletters, marketing materials, notification letters
- Provider materials: provider newsletters, performance reports, notification letters

Reports: quantitative proof of implementation, including:

- Redacted data sheets
- Analytical reports

These document types vary in their capacity to demonstrate implementation of standards with policies indicating intent to meet standards and reports showing evidence of implementation.

For each of the accreditation bodies, Table 1 below presents how many standards require the Issuer to provide process information, materials and/or reports, as well as how many require all types of

documentation. The numbers in the first three columns are not exclusive. For example, some of the 54 AAAHC standards that require documentation of processes also require materials and/or reports.

Table 1. Number of Standards by Type of Documentation Required

	Documented Process	Materials	Reports	Combination of All Document Types
AAAHC (90 total standards)	54	47	11	25
percent	60%	52%	12%	28%
NCQA (47 total standards)	30	20	28	40
percent	64%	43%	60%	85%
URAC (156 total standards)	147	66	22	37
percent	94%	42%	14%	24%

NCQA requires the most rigorous documentation, with 85 percent of standards requiring all three categories of documents as evidence. URAC and AAAHC rely primarily on documented processes. Only 12 percent of AAAHC standards and 14 percent of URAC standards require the Issuer to provide reports to document compliance, compared to the 60 percent of NCQA standards that require reports.

Mandatory Compliance Areas

AAAHC designates five standards as "must fully meet" standards. To achieve accreditation, Issuers must be fully compliant with these standards. Failure to do so may result in denial of accreditation.

NCQA standards designate eight must-pass elements. These standards must be scored at least a "met" designation and are subject to corrective action if unmet. If an Issuer fails three must-pass elements, the plan may be denied accreditation.

NCQA has four standards designated as critical. These standards are basic requirements the Issuer must meet to achieve the objectives of the element, or an essential component of the element that exists to protect members. The Issuer must be scored "yes" in all critical factors of an element to earn an element score of at least "partially met".

URAC has 78 standards with at least one sub-element designated as mandatory. Mandatory standards must be met at 100 percent compliance in order to achieve a full accreditation.

As shown in Table 2 below, each accrediting body conducts file review for specific standards to validate documentation in medical records. When any of the following functions are delegated, file review includes records from Issuers and delegate organizations.

Table 2. Standards Requiring File Review

	AAAHC	NCQA	URAC
Credentialing and Recredentialing	X	X	X
Utilization Management denials		X	X
Utilization Management appeals		X	X
Case Management		X	X
Delegation Oversight			X
Utilization Management review		X	X
Clinical Records	X		
Health Plan Personnel Records	X		X
Provider Site Review	X		

Data Requirements

While there is significant overlap between the data reporting requirements for QHPs and commercial health plans, CMS requires Issuers report on QRS measures for their QHPs. As identified in the Health

Insurance *Exchange 2020 Quality Rating System Measure Technical Specifications* report, the QRS is a set of clinical quality measures including a subset of HEDIS measures and Pharmacy Quality Alliance (PQA) measures.[7] The measure set also includes survey measures based on questions from the Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey). Using Issuer-submitted data, CMS calculates QHP quality performance ratings on a five star rating scale.

AAAHC and URAC require Issuers seeking accreditation to submit QRS data for their Marketplace line of business. NCQA requires that Issuers report the commercial HEDIS/CAHPS set and the QRS set for its QHP line of business.

Unique Features

Each accrediting body has unique features in its accreditation process and standards described below.

AAAHC conducts an onsite survey to assesses standards of organization governance, staffing, and fiscal solvency. The site visit includes observation of processes and procedures, staff interviews, and document review. Specific elements in these areas include governing body responsibilities, administrative policies and procedures, financial controls, organizational lines of accountability, information systems, human resources policies, and the compliance program. AAAHC accreditation standards contain a domain for clinical records and health information. This domain assesses clinical record information systems, maintenance of medical records, and completeness of medical record documentation. AAAHC also assesses the environment of care and safety of the contracted provider network. This domain of standards review includes infection control processes; emergency and disaster preparedness; and physical accessibility.

NCQA standards contain a comprehensive review of population health management, including developing a program strategy, population identification, delivery system supports, wellness and prevention, and an evaluation of the effectiveness of the population health management impact. NCQA accreditation standards also contain additional modules for specific program areas, including Long Term Services and Supports, Medicare Advantage, Medicaid, and Special Needs Plans. Issuers undergoing accreditation review may select any of these modules for review as applicable to their business products.

Prior to 2020, NCQA assigned up to 50 points based on standards documents (processes, policies and procedures) and up to 50 points for measures (HEDIS and CAHPS reporting). As of 2020, NCQA requires the Issuer to meet at least 80 percent of applicable points in each standards category and to submit HEDIS and CAHPS annually after the first full year of accreditation. NCQA's final report to the Issuer provides scores for each level of the survey factor, element and standard.

URAC has the largest number of accreditation standards, with a total of 156 standards. URAC accreditation standards are comprised of core standards representing basic elements necessary to promote health plan quality. Core standards are augmented with additional modules that are aligned with organizational functions and designed to meet business goals. Issuers can choose to be accredited based on core standards with the addition of one or more modules to show achievement in specific areas.

URAC has a module for Health Insurance Marketplace plans. This module contains standards for provider directory adhering to Marketplace requirements, standard format for presenting benefit options, and the QHP enrollee survey.

[7] CMS, Health Insurance Exchange 2020 Quality Rating System Measure Technical Specifications. September 2019. See Section 2 of the Technical Specifications document on the QRS Measure Set.

C. Accreditation Methodology and Survey Process

AAAHC, NCQA, and URAC each implement an accreditation survey process that begins well before the survey date. Table 3 shows the activities in which each accrediting body engages during the pre-survey, survey, and post-survey stages of the accreditation process.

Table 3. Accreditation Survey Process Stages

	AAAHC	NCQA	URAC
Pre-Survey	• Document gathering	• Off-site review of documents	• Desk review of documents
On-site Survey	• Staff interviews • Document review • Observation of processes	• File review	• Validation review via webinar
Post-Survey	• Assessment of compliance with standards; validation by third-party • Detailed report of survey findings • Mid-cycle survey	• Committee review of audit findings • Audit report • Health Plan ratings	• Committee review of findings & determination of accreditation status • Monitoring via annual performance measure & mid-cycle onsite review

AAAHC

AAAHC awards accreditation for three years when it concludes that the Issuer is in substantial compliance with the Standards and it has no reservations about the Issuer's continuing commitment to high-quality member care and services consistent with the Standards. Issuers must achieve compliance for "must fully meet standards".

Issuers seeking accreditation must submit final scores of validated performance measures to AAAHC annually for its QHP line of business. Failure to do so could serve as grounds for revocation of accreditation.

NCQA

To achieve accreditation, Issuers must earn at least 80 percent of applicable points in each standards category and submit audited HEDIS and CAHPS results. NCQA scores each standard based on established performance expectations for the standard, which is made up of one or more element used to determine how well the organization meets the standard's requirements. An element may include one or more factors (scored items), such as showing that a specific set of policies includes identified items. "Critical factors" are required to achieve the element and the issuer must be scored "yes" in all critical factors in an element to earn an element score of at least Partially Met. The following elements include critical factors:

- **Population Health Management 1, Element A** (Public Health Management Strategy Description)
- **Network Item 2, Element B** (Access to Behavioral Healthcare)
- **Utilization Management 11, Element E** (Procedures for Pharmaceutical Management – Considering Exceptions)
- **Credentialing and Recredentialing 7, Element B** (Assessment of Organizational Providers – Medical Providers)

Demonstrated performance is rewarded with element points based on factors or other aspects of the element that the Issuer must meet to get the points. Scoring is based on meeting element requirements, scoring text, scope of review, data source, look-back period and explanation. Each element is scored as

met, partially met or not met. If an element is not applicable to a product line the associated points are excluded from the category's maximum possible points.

NCQA scoring guidelines describe the decision-making principles used to evaluate the Issuer against standards but are not binding on the reviewer, as NCQA recognizes that individual circumstances may not be known ahead of time.

For Marketplace product lines accreditation standards are used to determine whether the Issuer can offer QHPs under the CMS requirements. If an Issuer does not submit QRS measures to CMS or get listed on Healthcare.gov, NCQA will not accredit the Marketplace product line or allow its accreditation to continue for that product line.

URAC

URAC's Scoring System has six distinct categories of standard elements:

- **Weight = 1**: Emerging Practice
- **Weight = 2**: Basic Infrastructure
- **Weight = 3**: Promotes Quality
- **Weight = 4**: Key Stakeholder Right / Empowers Consumers
- **Mandatory** = Non-weighted, mandatory element with a direct or significant impact on consumer safety and welfare. All mandatory elements must be met at 100 percent compliance in order to achieve a full accreditation
- **Leading Indicator** = Non-weighted, optional element highlighting effective practices not yet widely adopted in health care

URAC issues levels of accreditation depending on total points, mandatory standards, and leading indicators. The accreditation levels and scoring are described below.

- If one Mandatory standard element is not met = Conditional Accreditation
- If two Mandatory standard elements are not met = Corrective Action
- If three Mandatory standard elements are not met = Denial
- If all Mandatory standard elements are met:
    - ≥ 94 points/100 and complies 100 percent on at least one "Leading Indicator" standard the Issuer receives *Full Accreditation* with a designation of *Compliance with Leading Indicator(s)* on the Accreditation Summary Report
    - ≥ 94 points/100 = Full Accreditation
    - ≥ 90, but < 94 points/100 = Conditional Accreditation
    - ≥ 85, but < 90 points/100 = Corrective Action
    - < 85 points/100 = Denial

Accreditation with Areas of Poor Performance

Outside of the mandatory areas discussed above, an Issuer can perform poorly in one or more areas and still achieve accreditation. However, the accreditation bodies establish their overall performance requirements to make it difficult for poor performers to achieve full accreditation.

AAAHC. The AAAHC process appears to rely somewhat more than the other bodies on accreditor and oversight subjective assessment that the Issuer is in substantial compliance with the Standards, such that AAAHC has no reservations about whether the Issuer is committed to high-quality member care and services. To support AAAHC's ability to assess the Issuer's performance, to maintain accreditation during the three-year term, the Issuer must annually submit its performance measure scores to the body.

NCQA. An Issuer must earn at least 80 percent of applicable points in each applicable standards category and submit audited HEDIS and CAHPS results. Standards are used to determine a rating of "accredited".

URAC. To gain full accreditation, the Issuer has to score at least 94 points out of a possible 100 and comply completely on at least one "Leading Indicator" standard. Scoring of standards not designated as must pass is weighted, meaning the Issuer can score less than perfectly in that area and still get partial credit. If an Issuer fails to meet one or two standards, it has six months to address the deficiencies. Once the Issuer has fixed the deficiencies, URAC will reassess the organization. If more than two standards are not met the Issuer is not accredited but may fix the deficiencies and get reassessed.

D. Core Health Plan Functions

Utilization Management

Each body assesses utilization management policies, procedures, and information provided to members and providers. Table 4 shows each accreditation body's utilization management requirements and notes where success on an element is mandatory for accreditation. NCQA and URAC conduct file review of utilization management decisions. Several standards are mandatory, must-pass elements in order to achieve accreditation. While AAAHC requires the use of clinical review criteria to make utilization decisions, AAAHC lacks many of the utilization management (UM) standards that NCQA and URAC require. AAAHC also does not conduct file review.

Table 4. Utilization Management Requirements by Accreditation Body

	AAAHC	NCQA	URAC
UM program has clearly defined structures and processes and assigns responsibility to appropriate individuals		X	X
Clinical review criteria: utilization decisions are based on sound clinical evidence; specifies procedures for appropriately applying the criteria	X	X	X
Members and practitioners can access staff to discuss UM issues		X	X
On-site review requirements			X
Limitations on use of non-clinical staff		M	M
Clinical reviewer qualifications		M	M
Peer clinical review		M	M
Drug UM clinical review requirements		M	M
Clinical review timeframes		M	X
Written notification of clinical review decisions		M	M
For mental health and/or substance use disorder (MH/SUD) benefits, utilization management protocols do not have more restrictive nonquantitative treatment limitations.			X
The organization has UM system controls to protect data from being altered outside of prescribed protocols		M	

M= mandatory or must-pass element

Both NCQA and URAC have several utilization management standards that are mandatory or must-pass elements. An Issuer could not fail these UM standards and still receive accreditation. None of AAAHC's utilization management standards are mandatory/must pass. NCQA and URAC also conduct file review for utilization management. Delegated providers are included in the file review process.

Disease Management

None of the three accrediting bodies evaluates a stand-alone set of disease management standards. Instead, disease management concepts are incorporated into other domains for population health, quality management, or member relations. In general, the health care industry is moving away from disease management towards population health management and patient-centered care management along a risk continuum. This is reflected in a focus on health risk assessment, care management by risk, and health management along a continuum from wellness to complex case management. Table 5 presents the requirements related to disease management used by each accreditation body.

- URAC standards cover processes such as self-management and health risk appraisals rather than standards related to maintaining a disease management program or strategy.
- NCQA has the most comprehensive standards for disease management. Developing a strategy, identifying at risk populations, implementing interventions, and evaluating outcomes is part of NCQA's population health strategy and program requirement. Issuers must show they have strategies for managing disease management focus populations, including members with multiple chronic illnesses and members with emerging risk.
- AAAHC has no standards for disease management.

Table 5. Disease Management Requirements by Accreditation Body

Requirement	AAAHC	NCQA	URAC
Self-Management Tools. The organization makes self-management tools available to appropriate members.		X	X
Health Risk Assessment Tool. The organization has a template for health risk appraisal used during new enrollee outreach to assess need for health education or additional assessment/evaluation for care management programs. Post-assessment, establish a written policy and/or documented procedure to refer potentially high-risk members to case management, disease management and/or member education programs.		X	X
Population Health Management (PHM). The organization outlines its PHM strategy for meeting the care needs of its members, including for those with emerging risk and those managing multiple chronic illnesses. The strategy must identify: ▪ Goals and populations targeted for each of the four areas of focus. (*critical factor) ▪ Programs or services offered to members. ▪ Activities that are not direct member interventions. ▪ How member programs are coordinated. ▪ How members are informed about available PHM programs.		X	
Programs with Interactive Content. The organization informs members eligible for programs that include interactive contact.		X	
Member Data for Population Health Management. The organization systematically collects, integrates and assesses member data to inform its population health management programs.		X	X
Member Demographics and Needs. The organization annually: ▪ Assesses the characteristics and needs, including social determinants of health, of its member population. ▪ Identifies and assesses the needs of relevant member subpopulations.		X	
Updating PHM. The organization annually uses the population assessment to: ▪ Review and update its PHM activities to address member needs.		X	M

Requirement	AAAHC	NCQA	URAC
▪ Review and update its PHM resources to address member needs. ▪ Review community resources for integration into program offerings to address member needs.			
Risk Stratification. At least annually, the organization segments or stratifies its entire population into subsets for targeted intervention.		X	
Self-Assessment. The organization has a systematic process to evaluate whether it has achieved its goals and to gain insights into areas needing improvement.		X	
Organizational Improvement. The organization uses results from the PHM impact analysis to annually: ▪ Identify opportunities for improvement. ▪ Act on one opportunity for improvement.		X	

M= mandatory or must-pass element

NCQA does not have must-pass requirements for any of its population health management standards. One standard related to establishing goals and identifying target populations for each of four required focus areas is a critical element. For critical elements, all factors must be met to achieve a minimum threshold of performance.

URAC has one mandatory element for a process that may be part of a disease management program. URAC requires that plans provide targeted communication and outreach to consumers as appropriate based upon demographics, health risk, claims history, or other segmentation techniques chosen by the organization.

Since there are a limited number and scope of standards related to disease management, plans may perform poorly and still achieve accreditation.

Grievances and Appeals

Each accrediting body reviews grievances and appeals according to federal and state requirements through a combination of policies, procedures, and materials review. NCQA and URAC also conduct file review of both grievances and appeals to ensure appropriate and timely handling of these issues. As noted in Table 6, NCQA and URAC both require Issuers show success on several must-pass, mandatory standards.

NCQA has separate standards for grievances and appeals related to behavioral health services.

Table 6. Grievance and Appeals Requirements by Accreditation Body

Requirement	AAAHC	NCQA	URAC
The organization has written policies and procedures for thorough, appropriate, and timely resolution of member appeals.	M	X	M
The organization adjudicates member appeals in a thorough, appropriate, and timely manner.	M	M	M
The organization has policies and procedures for registering and responding to oral and written complaints (grievances) that include: ▪ Documentation of the substance of complaints and actions taken. ▪ Investigation of the substance of complaints. ▪ Notification to members of the resolution of the complaint and, if there is an adverse decision, the right to appeal. ▪ Standards for timeliness, including standards for urgent situations. ▪ Provision of language services for the complaint process.	M	X	M

Requirement	AAAHC	NCQA	URAC
Using valid methodology, the organization annually analyzes nonbehavioral complaints and appeals.	X	X	X
The organization annually identifies opportunities for improvement, sets priorities and decides which opportunities to pursue based on analysis of the following information: member complaint and appeal data.	X	X	X
Using valid methodology, the organization annually: evaluates behavioral healthcare member complaints and appeals.		X	
The organization works to improve members' experience with behavioral healthcare and service by annually: ▪ Assessing data from complaints and appeals or from member experience surveys. ▪ Identifying opportunities for improvement. ▪ Implementing interventions, if applicable. ▪ Measuring effectiveness of interventions, if applicable		X	

M= mandatory or must-pass element

Each accrediting body has mandatory, must-pass standards for grievances and appeals. NCQA and URAC both conduct file review to ensure appropriate and timely processing of grievances and appeals. File review includes delegate files.

Across the three core functions of utilization management, disease management, and grievances and appeals NCQA has the most comprehensive set of standards. URAC includes a comprehensive assessment of utilization management and grievances and appeals but lacks a disease or population health management focus. AAAHC does not conduct file review for utilization management or grievances and appeals.

E. Alignment with Key Areas

In assessing the accreditation bodies' alignment with Covered California's goals and priorities, we reviewed several areas of particular importance to the Marketplace: health equity, quality improvement, network performance and delivery system reform.

Health Equity

The accreditation bodies are not focusing on health equity in the way Covered California has been. However, while AAAHC and URAC do not specifically address the collection of member demographics or the use of such data to assess and reduce health disparities, NCQA does requires the collection of race, ethnicity and language information. Further, the standards explicitly note that data collection is required for assessing member needs, which itself is required for an organization to understand whether its network of primary care, behavioral health and specialty providers meets member needs and preferences. NCQA's Distinction in Multicultural Health Care addresses many elements of health equity as envisioned by Covered California, but these requirements are not part of the core NCQA standards or the other bodies' requirements.

Quality Improvement

Each accrediting body requires a comprehensive set of standards for Quality Improvement, including implementation of a comprehensive Quality Improvement Program and Work Plan; maintenance of quality improvement governance and resources; administration of quality improvement activities (including in the areas of continuity and coordination of care, coordination of physical and behavioral health, and member satisfaction); monitoring, analysis, and improvement of quality performance measures and health outcomes; and conducting an annual Quality Improvement Program Evaluation.

Issuers are required to submit documented processes, quality improvement program documents, sample member and provider materials, and analytical reports as evidence of compliance.

Network Performance

The accreditation bodies require Issuers to show that they are selecting and maintaining high performing providers in their network. For example, AAAHC Chapter 8 requires the Issuer to adopt policies and procedures for assessing and monitoring providers' clinical documentation. Chapter 10 requires the plan to regularly analyze the quality of care provided to members and to monitor member satisfaction and care continuity and coordination. In section Quality Improvement (QI) 2, NCQA indicates that provider contracts should include language about the plan's intent to use provider quality information for quality improvement and for reporting to members. URAC's P-NM 3 (Provider Selection Criteria) requires provider selection criteria to address quality of care and service. The standard notes that quality of care must be used for network decisions but is not required as consumer information. The accreditation entities do not have standards or requirements that mirror Covered California's interest in ensuring plan members have access to useable information on provider quality.

Delivery System Reform

Delivery system reform is not a focus for any accrediting body. Accreditation is instead focused on health plan requirements for network management and adequacy. NCQA does have one standard, PHM3 – Value-Based Payment Arrangement, that requires an organization to demonstrate at least one VBP arrangement and report the percent of total payments made to providers.

F. Assessment of Accreditation Bodies on Rigor, Performance Measurement, Alignment

This section assesses the three accreditation bodies in terms of alignment with Attachment 7, the rigor of the requirements, and the extent to which performance measurement is employed. Each of these factors were assessed on a scale of minimal, low, moderate, and high.

Rigor. To determine rigor, we assessed the types of documents the accreditation body requires to establish compliance with standards, including assessing whether the documents require proof of outcomes. On the low end of rigor were documented processes such as policies and procedures, program documents, and workflows. These documents represent the intent to implement but do not require the Issuer to show that implementation occurred. In the mid-range of rigor are materials documenting that members and providers were provided with required information. Examples include member notification letters, newsletters, and member marketing and educational materials. High rigor documents are those that demonstrate outcomes through performance measures, redacted reports of member or provider data, or analytical reports. If a combination of documents is required, this was rated as higher rigor than one type of document alone.

Performance Measures. We identified accreditation standards that require the use of quality and performance measures, benchmarks, or required data elements to demonstrate compliance. We further reviewed the definition of performance measures for similarity to the data requirements in Attachment 7. Accreditation standards that require that established goals or benchmarks are met were rated higher than standards that require the use of data.

Alignment. To determine alignment with Attachment 7, we compared accreditation standards with the Attachment 7's required elements. We reviewed the language and intent of accreditation standards compared to the description of required elements in Attachment 7. High alignment was assigned when accreditation standards covered a majority of requirements as described in Attachment 7. Minimal alignment was assigned when an accreditation standard addressed a minimal number of Attachment 7

elements. In most cases, accreditation standards did not address Attachment 7 elements and were rated as "not applicable".

For example, the Measuring Care to Address Health Equity article in Attachment 7 includes a requirement to measure disparities in care by racial and ethnic identity and by gender. The standard further requires measures for diabetes, hypertension, asthma, and depression.

- AAAHC has a Network Adequacy standard that requires that race, ethnicity, and the cultural and spiritual needs of members are used to analyze performance and satisfaction data.
- NCQA has a Network Management standard that requires Issuers to assess practitioner availability by culture, ethnicity, race, and spoken language. The standard further requires that the practitioner network meet member needs for culture, ethnicity, race, and language.
- URAC has a Quality Management standard that requires the identification and tracking of performance measures for access to care but does not specify analysis by race, ethnicity, or gender.

All three accrediting bodies have low alignment with the requirements of the Attachment 7 elements, as none specified measures for the identified chronic conditions. AAAHC was assessed as low rigor as it only requires Issuers to provide their policies. NCQA was assessed as high for rigor for requiring both policies and data reports. URAC was assessed as moderate for rigor as it requires policies for measurement and performance analysis. AAAHC and NCQA were assessed as moderate for performance measures as they require data analysis by race and ethnicity. URAC was assessed as low for performance measures because it requires performance measures for access but does not specify a requirement for analysis by race, ethnicity, or gender. While we describe alignment as low in some areas, we noted that alignment varied among the elements, often based on whether the element is related to what could be considered a core health plan function, as described earlier.

Article 1. Improving Care, Promoting Better Health and Lowering Costs

Rigor:

- **AAAHC.** Each standard uses a combination of documented processes, materials, reports, and onsite interviews.
- **NCQA.** Requirements, including documented process, materials, and reports, vary across standards.
- **URAC.** Predominantly documented processes and materials.

Performance Measures:

- **AAAHC.** Network adequacy standards require benchmarks and measures.
- **NCQA.** Network adequacy standards require benchmarks and measures.
- **URAC.** Network adequacy standards require benchmarks and measures.

Alignment:

- **AAAHC.** Low alignment, as AAAHC does not contain standards addressing most of the elements for improving care, promoting better health and lowering costs. AAAHC does include a standard for health information systems, require that member experience is used to assess network adequacy, and require members are given information about treatment options.
- **NCQA.** Low alignment, as NCQA does not contain standards addressing most of the elements for improving care, promoting better health and lowering costs. NCQA does require that member experience is taken into account for network access and availability and provides members with information on their financial responsibility for drug costs.

- **URAC.** Low alignment, as URAC contains several of the elements in Article 1 including the use of quality of care and quality of service to establish provider selection criteria, the use of clinical factors in addition to cost for formulary development, and data exchange with providers.

Article 2: Provision and Use of Data and Information for Quality of Care[8]

Rigor:

- **AAAHC.** Submission of QRS data.[9]
- **NCQA.** Submission of HEDIS and CAHPS data[10]
- **URAC.** Submission of QRS data.

Performance Measures:

- **AAAHC.** QRS performance measures.
- **NCQA.** HEDIS and CAHPS performance measures.
- **URAC.** QRS performance measures.

Alignment:

- **AAAHC.** Minimal alignment, as AAAHC requires submission of QRS data (which includes some HEDIS measures); Attachment 7 specifies the inclusion of other non-HEDIS, non-CAHPS data.
- **NCQA.** Low alignment, as NCQA requires submission of HEDIS and CAHPS data; Attachment 7 specifies the inclusion of other non-HEDIS, non-CAHPS data.
- **URAC.** Minimal alignment, as URAC requires submission of QRS data (which includes some HEDIS measures); Attachment 7 specifies the inclusion of other non-HEDIS, non-CAHPS data.

Article 3. Reducing Health Disparities

Rigor:

- **AAAHC.** Measures not addressed.
- **NCQA.** Documented process and reports.
- **URAC.** Measures not addressed.

Performance Measures:

- **AAAHC.** Measures not addressed.
- **NCQA.** Requires assessment of members' unmet needs, suggests inclusion of race, ethnicity, language and other factors for assessment.
- **URAC.** Measures not addressed.

Alignment:

- **AAAHC.** Minimal alignment, as collection of race and ethnicity data is not specifically addressed.
- **NCQA.** Moderate alignment due to required collection of ethnicity, race, linguistic data and explicitly ties data collection to ability to assess member needs and determine population health management structure and resource allocation. NCQA does not set requirements for the data elements to be included in an assessment of member needs. The assessment component requires the organization to address cultural, ethnic, racial and linguistic needs.

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[8] Issuers must submit data to the accrediting body for the lines of business they seek to have covered by the accreditation. This section identifies the data required for the QHP line of business.

[9] As noted earlier in the report, the QRS data set includes a subset of HEDIS measures and PQA measures.

[10] NCQA considers the Accreditable entity to be the reporting unit/line of business. The Issuer must submit data separately for each line of business and must include QHP results in the overall commercial line of business. The Issuer submits QHP-only data for QHP line of business accreditation and commercial data (inclusive of QHP data) for its commercial accreditation. NCQA will not accredit the Issuer for its Marketplace line of business if it does not submit QRS data to CMS.

- **URAC.** Minimal alignment as collection of race and ethnicity data is not specifically addressed.

Article 4. Promoting Development and Use of Effective Care Models

Rigor:

- **AAAHC.** Most standards are not applicable except for the behavioral health standard, which requires regular assessment and identification of performance improvement outcomes as part of QI activities, indicating moderate rigor.
- **NCQA.** Most standards require some level of documented process, reports and material.
- **URAC.** Primary Care Medical Home (PCMH) model is not required but can include PCMH to demonstrate support for health care activities that promote patient safety.

Performance Measures:

- **AAAHC.** Most standards are not applicable except for the behavioral health standard which requires identification of performance issues to be included in future QI activities indicating moderate rigor.
- **NCQA.** Requires establishing metrics for measuring high-volume behavioral health practitioners and geographic distribution and metrics for meeting appointment standards.
- **URAC.** Minimal performance measures but does include showing active support of care coordination activities that could include reimbursement mechanisms and/or incentives or other initiatives.

Alignment:

- **AAAHC.** Most standards are not applicable in this article; however, behavioral health standard is moderately aligned as it requires measuring quality of care delivered to members and assessing medical necessity and appropriateness of care including performance and improvement outcomes as part of QI activities.
- **NCQA.** Minimal alignment as the selection and assignment of primary care providers (PCPs) or the associated timeframes to make PCP selections or assignments are not required. Does include a relevant component that Issuers assess the cultural, ethnic, racial and linguistic needs of its members and adjust the availability of practitioners within its network to meet these needs.
- **URAC.** Most standards are not applicable in this article. URAC does provide that PCMH programs could be used to show active support of care coordination activities.

Article 5: Hospital Quality

Rigor:

- **AAAHC.** Minimal rigor requiring identification of standards and programs for patient safety and reporting of untoward events.
- **NCQA.** Low rigor that requires reporting the percentage of total payments made to providers and practitioners associated with each type of value-based payment (VBP) arrangement and a documented plan and strategy that includes patient safety as a focus area.
- **URAC.** No standards are applicable.

Performance Measures:

- **AAAHC.** Most standards are not applicable. No defined metrics.
- **NCQA.** Most standards are not applicable. No defined metrics.
- **URAC.** No standards are applicable.

Alignment:

- **AAAHC.** Most standards are not applicable, except for one standard that requires organizations to support and enhance hospitals' efforts to promote safety for patients. AAAHC minimally aligns in that they require hospital adequacy to ensure delivery of health care in a safe and effective manner and addresses hospital environments and infection control.
- **NCQA**. Most standards are not applicable, although NCQA does include a standard that requires an organization to demonstrate that it has at least one VBP arrangement.
- **URAC.** No standards are applicable.

Article 6: Population Health: Preventive Health, Wellness and At-Risk Enrollee Support

Rigor:

- **AAAHC.** Requires policies and procedures and member materials such as newsletters or bulletins.
- **NCQA.** Documented process, materials such as screenshots or websites, and files demonstrating compliance.
- **URAC.** Written policies and/or documented procedures that detail how to protect the confidentiality of individually identifiable health information, and member materials that provide targeted communication and outreach to consumers as appropriate based upon demographics, health risk, claims history, or other segmentation techniques.

Performance Measures:

- **AAAHC.** No defined metrics.
- **NCQA.** Most standards included no defined metrics; however, one standard included measuring effectiveness of PHM strategy by requiring submission of quantitative results for relevant clinical, cost/utilization and experience measures. Submission requirements include an interpretation of results against a benchmark or goal, and when appropriate, documentation of acting on at least one improvement opportunity.
- **URAC.** No defined metrics.

Alignment:

- **AAAHC**. Low to moderate alignment as they require health education promotion and prevention which includes addressing tobacco cessation and weight management. Requires materials with applicable information be made available for threshold languages with access to language assistance services as needed. Requires confidentiality of member records and a comprehensive member needs assessment to determine the need for relevant health education and disease prevention programs. AAAHC does not require organizations to report the number and percent of enrollees who use services.
- **NCQA**. Low to moderate alignment which includes requirements to offer wellness services focused on preventing illness and injury, promoting health and productivity and reducing risk. Requires organization to provide information on smoking and tobacco cessation and healthy weight (BMI) maintenance. Includes some of the components as part of self-management tools and complex case management procedures, i.e. cultural and linguistic needs and preferences. Requires an organization to help adult members identify and manage health risks through evidence-based tools that maintain member privacy and includes that an organization must have the capability to administer a Health Assessment. Requires members to have access to care management through multiple avenues including referrals. Requires an organization to demonstrate continuity of care and assistance with member's transition to other care when their benefits end along with notification to members about alternatives and resources for continuing care.

- **URAC.** Low to moderate alignment which includes consumer communications plan and targeted outreach providing members with materials explaining how to obtain prevention and wellness services and targeted communication based on health risk, i.e. smoking cessation and obesity awareness. Includes ensuring confidentiality and security of information, along with confidentiality of individually identifiable health information. Upon enrollment requires providing consumers with access to a health risk assessment tool that: (a) Collects information about the risk factors associated with the various risk-types addressed in the tools; (b) Is evidence-based; (c) Is reviewed by the organization's senior clinical staff person or clinical oversight body; (d) Reports to the individual consumer an overall health risk assessment tool score; (e) Utilizes biometric screening and other screening results; and (f) Provides suggested actions to an individual consumer to assist the consumer in managing personal health.

Article 7. Patient-Centered Information and Support

Rigor:

- **AAAHC.** Documented process, policies, materials.
- **NCQA.** Documented process, reports, materials.
- **URAC.** Documented process, policies, materials, consumer documents, scripts, web site review, interviews, reports of denied visits.

Performance Measures:

- **AAAHC.** No defined metrics.
- **NCQA.** No defined metrics.
- **URAC.** For out of network care, reviews report of denied emergency room visits.

Alignment:

- **AAAHC.** Does not address consumer-facing provider information. Requires policies and procedures for informing consumers, does not get to the level of member-specific cost or provider information. Requires access to personal health information but does not mandate a portal or other access point. Does not address specific member tools, use of personal health information or patient engagement (the latter beyond providing members information about how to engage).
- **NCQA.** Does not address consumer-facing provider information. Requires provision of information on cost, benefits, how to access care. Does not address specific member tools, use of personal health information or patient engagement.
- **URAC.** Does not address consumer-facing provider information or other specific member tools. Defines but does not specify requirements for patient engagement.

Article 8. Payment Incentives to Promote Higher Value Care

Rigor:

- **AAAHC.** No standard.
- **NCQA.** Documented process and materials.
- **URAC.** No standard.

Performance Measures:

- **AAAHC.** No standard.
- **NCQA.** No standard.
- **URAC.** No standard.

Alignment:

- **AAAHC.** No standard.

- **NCQA.** Low alignment as NCQA has a standard to establish value-based payment for delivery system supports in population health management.
- **URAC.** No standard.

G. Market Reach

Nationally, NCQA conducts the vast majority of Issuer accreditations, over 20 times more than AAAHC and 18 times more than URAC. NCQA conducts more Issuer accreditations than AAAHC and URAC combined in California, including all but two California Issuers offering QHPs. Adoption of HEDIS and CAHPS measurement is one possible reason that NCQA has come to dominate the market to an extent that NCQA is almost synonymous with Issuer accreditation. HEDIS and CAHPS have become required tools for programs such as Medicare and Medicaid.[11] Across commercial and public sector markets, Issuers use the scores to market themselves, highlighting areas of high performance. NCQA has integrated these performance measurement tools, aligning its accreditation process with quality measurement and creating a natural connection for many Issuers.

Table 7. Accredited Health Plan Issuers Nationally and in California

Accreditation Body	All Accreditations Nationally[12]	All Accreditations in California	QHP Accreditations Nationally	QHP Accreditations in California
AAAHC	32	4	1	1
NCQA[13]	712	48	195	9
URAC	39	1	18	1

Almost all Issuers offering QHPs in the State-Based Marketplaces are accredited by NCQA, including all participating Issuers in the Connecticut, Idaho, Maryland, Massachusetts, Minnesota, Nevada, Rhode Island, Vermont, Washington D.C. and Washington State Marketplaces. Six of the Colorado Marketplace's eight Issuers are accredited by NCQA and the other two are URAC-accredited. Enrollees in twenty-two of Colorado's 64 counties have only one Marketplace Issuer option in 2020, the NCQA-accredited Anthem. All but two of New York's Marketplace Issuers have NCQA accreditation.[14]

In California, NCQA accredits all but two Issuers offering QHPs on the Marketplace. Both the plan accredited by AAAHC and the URAC-accredited plan are smaller, regional plans with limited enrollment. Chinese Community Health Plan, which is URAC-accredited, enrolls less than 1 percent of all Covered California members. AAAHC accredited Valley Health Plan covers about 2 percent of all QHP enrollees in the state. While several NCQA accredited plans in California have small enrollments, the three Issuers that together enroll 72 percent of Covered California consumers are all NCQA accredited.

AAAHC is primarily focused on accrediting ambulatory health care practices and accredits a small number of health plan Issuers. Its founding members and partnerships show an orientation to health

[11] Medicare Advantage plans are required to report HEDIS results. Forty states utilize HEDIS in their Medicaid programs. A sample of Medicare Advantage plan consumers are surveyed with CAHPS each year. Title XXI (CHIP) programs must conduct CAHPS for enrollees, including those in expansion Medicaid programs, separate CHIP programs and combination programs. Title XIX (Medicaid) programs are encouraged to conduct CAHPS, though not required to.

[12] All plan totals include all the plans in different markets operated by the same organization. For example, a Medicaid, Medicare and QHP plan offered by the same Issuer are counted as three plans.

[13] Including scheduled and in process accreditations.

[14] The plan list from the New York Marketplace includes two plans that were not listed as accredited by any company. One plan is owned by the City of New York and the other by a consortium of hospitals, so it may be that they are accredited under different organizational names.

care delivery and a collaborative practice model designed to support improvement over time rather than assess current achievement. AAAHC has accredited Issuers of any type in only Washington DC, seven states (California, Florida, Illinois, Maryland, Massachusetts, Virginia and Wisconsin) and Guam and Puerto Rico. In DC, Maryland, Illinois and Virginia the accredited plans are all Federal Employees Health Benefits group plans.

Accreditation Bodies' Reach and Impact of Relevant Universe on Standards Strength

At the time of this review, 195 Marketplace Issuers (177 individual and 18 group nationally) hold NCQA accreditation, six are in process, and another eight have been scheduled. Eighteen Marketplace plans are URAC accredited. The AAAHC list of accredited entities includes one Issuer offering QHPs, along with three Medi-Cal plans.

NCQA is the market leader both in total number of Issuers accredited, and accreditor of Issuers known to be high quality. Accrediting many strong plans can have the result of increasing standards over time, as NCQA's comparison group is high achieving. A high-achieving comparison group provides the context for high expectations of achievement across all Issuers.

We reviewed the QRS scores for NCQA and URAC and did not find a meaningful difference between the QHPs' scores by accreditation body. Both organizations have accredited QHPs with scores ranging from 2 to 5 stars.[15] AAAHC accredits one QHP, challenging an effort to meaningfully assess plan quality compared to plans accredited by the other entities. All but two of California's Marketplace Issuers are accredited by NCQA, making a comparison of California QHPs' star ratings of little value. However, the Issuers considered market leaders nationally are all NCQA-accredited. This includes Blue Cross Blue Shield of Massachusetts, Blue Cross Blue Shield of Michigan, and the Kaiser Permanente plans. Over time, attracting high performance Issuers may have created a positive feedback loop in which Issuers see that high performers utilize NCQA and themselves seek NCQA accreditation as a way both to become stronger organizations and to gain the benefit of association with the market leader and other well-regarded Issuers.

NCQA Health Plan Ratings

In addition to accrediting Issuers, NCQA rates Medicare Advantage, Medicaid and commercial health plans using its own methodology and rating system. NCQA publishes information on over a thousand health plans based on clinical quality, member satisfaction and NCQA Accreditation Survey results (the latter is included for Issuers that are NCQA accredited).[16] Ratings emphasize health outcomes and members' opinions. The methodology is similar to the Centers for Medicare and Medicaid Services five-star quality rating system used with the Medicare. NCQA makes the results of its star rating methodology public on its web site to allow consumers to use the information during Medicare and commercial open enrollment.[17] The 2019-20 ratings did not include QHPs.[18]

Participation in the NCQA ratings allows plans to promote strong performance not only on its own merits but in comparison to other plans in the market. In addition, many states use NCQA's benchmarks for their Pay for Performance (P4P) programs and plans often use it for provider P4P.

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[15] NCQA has accredited one QHP with a QRS of 1 star.

[16] NCQA announced that due to COVID-19, it will not release 2020–2021 Health Plan Ratings for any product line.

[17] https://www.ncqa.org/hedis/reports-and-research/ratings-2019/ The rating methodology is available at: https://www.ncqa.org/wp-content/uploads/2019/09/20190827_2019_Health_Plan_Ratings_Methodology.pdf

[18] NCQA, NCQA Health Insurance Plan Ratings Methodology August 2019. The report includes the following: "This year's ratings do not include Exchange plans because they have not developed sufficient data for analysis," which may refer to years of accreditation, as QHPs report CAHPS and HEDIS data.

While NCQA rates health plans, the size of its accreditation line of business does not impact its ability to conduct its rating work. NCQA utilizes information across Issuers, including those accredited by other organizations. NCQA benchmarks are not built on its accredited plans only and the universe of its accredited organizations is not what determines its evaluation benchmarks.

Purchaser Endorsements

As noted above, AAAHC, NCQA and URAC are the three bodies authorized to accredit QHPs. A number of other governmental entities endorse specific accreditation bodies. The U.S. Department of Health and Human Services, along with seven states (Connecticut, Iowa, Louisiana, Massachusetts, Michigan, Minnesota and Utah) endorse both NCQA and URAC as accreditation bodies. Texas and Illinois name all three accreditation bodies as approved. No endorser promotes the use of AAAHC without also endorsing NCQA and URAC. Other states require Issuer accreditation without specifically naming one or more entity. The Appendix provides a list of state and federal purchasers accreditation endorsements.

In California, while DHCS does not require Medi-Cal plan accreditation by NCQA, 12 of the 26 Medi-Cal plans have NCQA accreditation and another four are waiting for an accreditation visit. In January and February 2020, DHCS held meetings of a NCQA workgroup to discuss whether to officially deem certain Medi-Cal requirements based on NCQA accreditation and how other states approach this. In a presentation to the workgroup, Valerie Martinez, Director of Clinical Quality at UnitedHealthcare Community Plan of California identified NCQA accreditation as the “gold standard for quality”, noting that the process focuses on wellness, care coordination, access, disease management and consumer satisfaction. To date no changes have been made in this area and future changes may be delayed as the overall CalAIM project is on hold due to the global pandemic.

Medicare Deeming

NCQA has a long-standing relationship with CMS, which includes the use of deeming for particular program elements. CMS requires that Medicare SNPs meet model of care standards for this high-needs population. CMS supports the use of NCQA’s Medicare Advantage Deeming model for assessing how SNP plans implement their model of care, including monitoring and evaluating model of care effectiveness through performance measures. A Medicare SNP that meets NCQA’s deeming module requirements is deemed for Medicare requirements for SNP model of care. This allows the plan to confirm that its model of care is designed to meet the population’s needs, as well as to bypass auditing of the model of care requirements.

Recommendations

NCQA Supports Covered California's Strategic Goals

As noted in Figure 1, Covered California is working to assure quality, equitable care for Californians using a range of identified delivery system reform drivers. In reviewing each of the accreditation bodies, HMA found variation in their standards, required documentation, survey process, and scoring, as well as in rigor and fit with the Attachment 7 goal of facilitating system reform. While each accrediting body has its own strengths, ***NCQA is the best fit for Covered California's goals of achieving health plan quality and ensuring rigor in core areas of health plan control.***

AAAHC relies heavily on the onsite audit to confirm that standards are achieved. The onsite process includes observation of processes, staff interviews, and document and file review. Due to its history accrediting provider entities, AAAHC also focuses on clinical processes that the other accrediting bodies do not assess. The AAAHC process includes assessment of performance against standards for clinical record documentation and infection control, as well as provider site review. AAAHC also focuses on standards for organizational structure such as human resources, personnel records, and disaster preparedness.

AAAHC has limited standards in utilization management and disease management, lacks rigor in some assessed areas, and fails to conduct file review for Case Management and Utilization Management. While URAC standards take a unique modular approach and it is strong in its assessment of internal plan workings (such as interdepartmental coordination and business relationships), URAC does not have standards on complex care management, an area of particular interest to Covered California. NCQA requires more rigor in the documentation required to assess compliance with standards.

NCQA accreditation standards and scoring rely heavily on demonstrated quality outcomes. NCQA requires that HEDIS and CAHPS data are submitted as part of the accreditation process. Prior to 2020, half of the points an Issuer could earn toward accreditation were based on HEDIS and CAHPS performance compared to national and regional HEDIS and CAHPS benchmarks for the relevant product line.[19] The other half of the points were based on standards (including processes, policies and procedures). Starting in 2020, the Issuer must meet at least 80 percent of applicable points in each standards category and submit HEDIS and CAHPS data after their first full year of accreditation and annually thereafter.

NCQA accreditation standards include a Population Health Management domain. This standard is unique to NCQA and requires a systematic approach to develop a population health strategy, program, member and delivery systems supports, and impact evaluation.

In addition to NCQA's strengths as an accreditation body, a requirement that all Covered California Issuers achieve NCQA accreditation will be minimally disruptive. NCQA is already the accreditation body for all but two Issuers currently offering QHPs on California's Marketplace. Requiring NCQA would cause no change for these Issuers. NCQA's alignment with HEDIS and CAHPS gives it a market advantage and allows the organization to focus on measures in common use across markets in California and nationally.

As discussed by Department of Health Care Services and stakeholders at NCQA workgroup meetings earlier this year, Medi-Cal deeming can be used to enhance state oversight. Almost half of Medi-Cal

[19] NCQA materials indicate that HEDIS and CAHPS data for Exchange products must be reported separately for that product line and included in the overall commercial product line data. NCQA, Section 1 of Standards and Guidelines for the Accreditation of Health Plans. 2019 (for surveys beginning on or after July 1, 2020)

managed care plans are NCQA accredited. Requiring Issuers to gain NCQA accreditation would support additional alignment with Medi-Cal.

Accreditation Can be Used to Assess Compliance with Core Health Plan Functions

Accreditation predominantly focuses on commonly accepted processes, measures, and goals for health plan operations and quality. While all three accreditation bodies demonstrated low to minimal alignment with Attachment 7 Articles overall, accreditation can be used to provide information and assurances that QHPs are meeting core contractual requirements embedded within Attachment 7.

While the reports that Issuers submit as part of accreditation do not on their own adequately provide the information or results to assess compliance with Attachment 7 overall or with any full Attachment 7 Article in its entirety, NCQA accreditation can be used as a proxy for program audits by Covered California. NCQA accreditation will provide Covered California with assurance that the Issuer is compliant with health plan principles and business functions. We recommend that Covered California request final audit reports from accreditation.

Appendix: Endorsements

Endorsements: Accreditation

State/Entity	Relevant Language (Accreditation)	Accreditation Body		
		AAAHC	NCQA	URAC
US Department of Health and Human Services	This notice announces the recognition of NCQA and URAC as recognized accrediting entities for the purposes of fulfilling the accreditation requirement as part of qualified health plan certification.		X	X
US Office of Personnel Management	A multi-state plan program (MSPP) Issuer must be or become accredited consistent with the requirements for QHP Issuers specified in section 1311 of the Affordable Care Act and 45 CFR 156.275(a)			
California	Providing copies of all final reports of independent private accrediting agencies (e.g. JCAHO, NCQA) relevant to Contractor's Medi-Cal line of business, including: 1) Accreditation status, survey type, and level, as applicable.		X	
Connecticut	Each access plan required under subdivision (1) of this subsection shall be in a form and manner prescribed by the commissioner and shall contain descriptions of at least the following: the health carrier's accreditation by NCQA that such health carrier meets said committee's network adequacy requirements or by URAC that such health carrier meets URAC's provider network access and availability standards.		X	X
Delaware	Each application for a Certificate of Authority as a Managed Care Organization shall be accompanied by Evidence of accreditation by a nationally-recognized managed care accrediting organization such as NCQA, the Joint Commission on Accreditation of Healthcare Organizations, or similar organization		X	
District of Columbia	The risk-based MCOs are required to obtain and maintain full NCQA Health Plan Accreditation. All MCOs are required to obtain NCQA Case Management Accreditation.		X	
Florida	To promote the quality of health care services provided by health maintenance organizations and prepaid health clinics in this state, the office shall require each health maintenance organization and prepaid health clinic to be accredited within 1 year of the organization's receipt of its certificate of authority and to maintain accreditation by an accreditation organization approved by the office, as a condition of doing business in the state.			
Georgia	The Contractor shall achieve NCQA Commendable or Excellent accreditation status within three (3) years after the Operational Start Date. Contractors that lose NCQA Commendable or Excellent status must regain the status within one (1) year.		X	
Hawaii	The health plan shall be accredited by the National Committee for Quality Assurance (NCQA) for its QUEST Integration program no later than when their current accreditation expires. For health plans undergoing accreditation for NCQA, health plans shall submit reports documenting the status of the accreditation process as required in Section 51.550.1.		X	

State/Entity	Relevant Language (Accreditation)	Accreditation Body		
		AAAHC	NCQA	URAC
Illinois	Pursuant to 305 ILCS 5/5-30 (a) and (h), if Contractor is serving at least 5,000 SPDs or 15,000 individuals in other populations covered by the HFS Medical Program and has received full-risk Capitation for at least one (1) year, then Contractor is considered eligible for accreditation and shall achieve accreditation by the NCQA within two (2) years after the date Contractor became eligible for accreditation.		X	
Indiana	Not later than January 1, 2011, the following must be accredited by the National Committee for Quality Assurance or its successor: (1) A managed care organization that has contracted with the office before July 1, 2008, to provide Medicaid services under a risk based managed care program.		X	
Iowa	The managed care organization shall attain and maintain accreditation by NCQA or URAC		X	X
Kansas	The CONTRACTOR(S) shall indicate whether they have achieved National Committee for Quality Assurance (NCQA) accreditation and LTSS Distinction for its Kansas Medicaid line of business, including the level of accreditation achieved. If they have not, the CONTRACTOR(S) shall obtain NCQA accreditation of at least "Accredited" and LTSS Distinction status within 24 months of the onset of delivering care to KanCare Members.		X	
Kentucky	If the contractor holds a current NCQA accreditation status it shall submit a copy of its current certificate of accreditation with a copy of its complete accreditation survey report,… If a Contractor has not earned accreditation of its Medicaid product through the National Committee for Quality Assurance (NCQA) Health Plan, the Contractor shall be required to obtain such accreditation within two (2) to four (4) years from the effective date of its initial MCO contract with the Commonwealth.		X	
Louisiana	If the Contractor is NCQA accredited for its Medicaid product covered by this Contract as of the operational start date of this Contract, the Contractor shall maintain full NCQA accreditation throughout the term of this Contract. 2.16.14.2 If the Contractor is not NCQA accredited for its Medicaid product covered by this Contract, the Contractor shall attain such accreditation.		X	
Maryland	To maintain NCQA accreditation, as set forth in 42 CFR §438.332(b) and COMAR 10.09.64.08 (Appendix H), and to provide the Department a copy of its most recent NCQA accreditation, including: a. Accreditation status, survey type, and level; b. Accreditation results, including: a. Recommended actions or improvements, b. Corrective action plans, and c. Summaries of findings; and c. Expiration date of accreditation.		X	
Massachusetts	The Contractor shall: 1. Be accredited by the National Committee on Quality Assurance (NCQA);		X	
Michigan	Contractor must hold and maintain accreditation as a managed care organization by the NCQA or URAC Accreditation for Health Plans.		X	X

State/Entity	Relevant Language (Accreditation)	Accreditation Body		
		AAAHC	NCQA	URAC
Minnesota	A health carrier that has obtained accreditation through the URAC for network management; quality improvement; credentialing; member protection; and utilization management, or has achieved an excellent or commendable level ranking from the National Committee for Quality Assurance (NCQA), shall be deemed to meet the requirements of subdivision 1.		X	X
Mississippi	The Contractor shall be accredited by the National Committee for Quality Assurance (NCQA) and provide to the Division, on an annual basis, any and all documents related to achieving such accreditation. The Division reserves the right to post accreditation status publicly on its website in accordance with 42 C.F.R. § 438.332. Accreditation status may also be posted to the related website operated by the Contractor.		X	
Missouri	The health plan shall obtain health plan accreditation, at a level of "accredited" or better, for the MO HealthNet product from NCQA within twenty-four (24) months of the first day of the effective date of the contract. The health plan shall maintain such accreditation thereafter and throughout the duration of the contract.		X	
Montana	A health carrier whose managed care plan has been accredited by a nationally recognized accrediting organization shall annually provide a copy of the accreditation and the accrediting standards used by the accrediting organization to the department.			
Nebraska	The MCO must attain health plan accreditation from the National Committee for Quality Assurance (NCQA). If the MCO is not currently accredited by NCQA, the MCO must attain NCQA accreditation within 18 months of the contract award.		X	
Nevada	Currently, the Division requires that MCO vendors be accredited by any nationally recognized organization that provides an independent assessment of the quality of care provided by the vendor The Division is considering requiring future Nevada Medicaid MCO vendors to be accredited by NCQA.			
New Hampshire	The MCOs shall be required to be accredited by NCQA, including all applicable Medicaid Standards and Guidelines and the MCOs must authorize NCQA to provide DHHS a copy of its most recent accreditation review,		X	
New Jersey	Each HMO shall submit, as part of the comprehensive assessment review process, evidence of the most recent external quality audit that has been conducted within three years of the date of the comprehensive assessment review.			
New Mexico	Nothing in this section shall prohibit a managed health care plan from submitting accreditation by a nationally recognized accrediting entity as evidence of compliance with the requirements of this section.			

State/Entity	Relevant Language (Accreditation)	Accreditation Body		
		AAAHC	NCQA	URAC
North Carolina	a. The PHP shall achieve accreditation by NCQA by the end of Contract Year 3. b. The PHP shall achieve NCQA LTSS Distinction by the end of Contract year 3.		X	
North Dakota	MCO shall inform STATE whether it has been accredited by a private independent accrediting entity and MCO must authorize the private accrediting entity to provide STATE a copy of its most recent accreditation review,			
Ohio	The MCP shall hold and maintain, or shall be actively seeking and working towards, accreditation by the NCQA for the Ohio Medicaid line of business.		X	
Pennsylvania	Obtain accreditation by a nationally recognized organization, such as National Committee of Quality Assurance (NCQA). 1. The PH-MCO must demonstrate evidence by submitting to the Department accreditation survey type and level, results of survey including recommendations actions and/or improvements, corrective action plans, and summaries of findings conducted by the accrediting national recognized organization.		X	
Rhode Island	Is accredited by the National Committee for Quality Assurance (NCQA) as a Medicaid Managed Care Organization		X	
South Carolina	The CONTRACTOR shall: 15.7.1. Achieve at a minimum "Accredited" status from NCQA within one (1) year of the effective date of this contract or within four years of entering the South Carolina Medicaid market, whichever comes first. 15.7.2. Secure, at a minimum, Interim Health Plan Accreditation status from NCQA prior to contracting with the Department. 15.7.3. In addition to the Interim Health Plan Status Accreditation status provision, the CONTRACTOR must continue its pursuit to achieve "Accredited" status within the timeframe detailed in this Section of the contract. 15.7.4. Maintain the "Accredited" status accreditation through the term of the contract.		X	
Tennessee	The CONTRACTOR shall maintain NCQA accreditation throughout the period of this Agreement.		X	
Texas	A health benefit plan issuer is presumed to be in compliance with state statutory and regulatory requirements if the health benefit plan issuer has received nonconditional accreditation by a national accreditation organization.			
Utah	The Contractor shall inform the Department whether it has been accredited by a private independent accrediting entity.			
Vermont	Each managed care organization shall be accredited by a national independent accreditation organization approved by the Commissioner.			
Virginia	As specified in 42 C.F.R. § 438.332, the Contractor must obtain and retain health plan accreditation by the National Committee for Quality Assurance (NCQA).		X	

State/Entity	Relevant Language (Accreditation)	Accreditation Body		
		AAAHC	NCQA	URAC
Washington	The Contractor shall have and maintain NCQA accreditation at a level of "accredited" or better.		X	
West Virginia	The MCO must achieve or maintain accreditation from the NCQA for their Medicaid lines of business by the beginning of each Contract year. The MCO must keep current accreditation from the NCQA for their Medicaid lines of business.		X	

Citations: Accreditation

State/Entity	Citation
US DHHS	https://www.gpo.gov/fdsys/pkg/FR-2012-11-23/pdf/2012-28440.pdf
US OPM	https://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04954.pdf
California	https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx
Connecticut	https://codes.findlaw.com/ct/title-38a-insurance/ct-gen-st-sect-38a-472f.html
Delaware	https://regulations.delaware.gov/AdminCode/title18/1400/1403.shtml
District of Columbia	https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/DHCF%20Quality%20Strategy%20DRAFT%20%282%29.pdf
Florida	http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0600-0699/0641/Sections/0641.512.html
Georgia	https://medicaid.georgia.gov/sites/medicaid.georgia.gov/files/related_files/site_page/GF%20Contract%20-%20Generic%20%28002%29.pdf
Hawaii	https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/RFP/QI-RFP-Final-Clean-SC12.pdf
Illinois	https://www.illinois.gov/hfs/SiteCollectionDocuments/2018MODELCONTRACTadministrationcopy.pdf
Indiana	http://iga.in.gov/legislative/laws/2018/ic/titles/012/#12-15-30-4
Iowa	https://www.legis.iowa.gov/docs/iac/rule/01-06-2016.441.73.2.pdf
Kansas	https://www.admin.ks.gov/offices/procurement-and-contracts/kancare-award
Kentucky	https://chfs.ky.gov/agencies/dms/dpqo/Documents/1%20Aetna%20-%20Full%20FY20%20Renewal%20with%20April%20Rates.pdf
Louisiana	http://ldh.la.gov/assets/medicaid/RFP_Documents/RFP3/AppendixB.pdf
Maryland	https://mmcp.health.maryland.gov/healthchoice/Documents/MCO%20Agreement%202019%20for%20CY%202019%20MCO%20file.pdf
Massachusetts	https://www.mass.gov/files/documents/2017/11/17/accountable-care-partnership-plan-model-contract_0.pdf
Michigan	https://www.michigan.gov/documents/contract_7696_7.pdf
Minnesota	https://www.revisor.mn.gov/statutes/cite/62K.12
Mississippi	https://medicaid.ms.gov/wp-content/uploads/2018/03/MSCAN-Contract-Jul2017-June2020-UHC.pdf
Missouri	https://dss.mo.gov/business-processes/managed-care/
Montana	https://leg.mt.gov/bills/mca/title_0330/chapter_0360/part_0030/section_0010/0330-0360-0030-0010.html
Nebraska	http://das.nebraska.gov/materiel/purchasing/5151/5151.html
Nevada	http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Public/AdminSupport/MC_Enhancement_Request_Public_Engagement_1.2020.pdf
New Hampshire	https://www.dhhs.nh.gov/ombp/medicaid/mcm-procurement.htm

State/Entity	Citation
New Jersey	https://casetext.com/regulation/new-jersey-administrative-code/title-11-insurance/chapter-24-health-maintenance-organizations/subchapter-7-continuous-quality-improvement/section-1124-72-external-quality-audit
New Mexico	http://164.64.110.239/nmac/parts/title13/13.010.0022.htm
North Carolina	https://files.nc.gov/ncdma/Contract--30-190029-DHB-Prepaid-Health-Plan-Services.pdf
North Dakota	https://www.nd.gov/dhs/services/.../survey-mco-medicaid-expansion.pdf
Ohio	https://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/Managed%20Care/Provider%20Agreements/Medicaid-Managed-Care-Generic-PA.pdf
Pennsylvania	http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/p_040149.pdf
Rhode Island	http://www.eohhs.ri.gov/LinkClick.aspx?fileticket=Xg4aJSQkl_M%3d&portalid=0
South Carolina	https://msp.scdhhs.gov/managedcare/sites/default/files/2018%20MCO%20Contract%20-%20Amendment%20IV%20Final.pdf
Tennessee	https://www.tn.gov/content/dam/tn/tenncare/documents2/vshp.pdf
Texas	https://statutes.capitol.texas.gov/Docs/IN/htm/IN.847.htm#847.005
Utah	https://medicaid.utah.gov/Documents/pdfs/managedcare/ACO%20-%20Healthy%20U%20Medicaid_Redacted%202018-01-01%20-%20182700622.pdf
Vermont	https://legislature.vermont.gov/statutes/section/18/221/09414
Virginia	http://www.dmas.virginia.gov/files/links/2325/Final%20Expansion%20Amendment%20Medallion%204.0%20Contract%202018.pdf
Washington	https://www.hca.wa.gov/assets/billers-and-providers/ipbh_fullyintegratedcare_medicaid.pdf
West Virginia	https://dhhr.wv.gov/bms/Members/Managed%20Care/MCOcontracts/Documents/WV_SFY20_MCO_Model_Contract_v9.pdf

Endorsements: Utilization Management

State/Entity	Relevant Language (Utilization Management)	Accreditation Body		
		AAAHC	NCQA	URAC
Alabama	The purposes of this chapter are to promote the delivery of quality health care in a cost-effective manner and assure that utilization review agents adhere to reasonable standards for conducting utilization review. UTILIZATION REVIEW AGENT… Any entity that has a current accreditation from the Utilization Review Accreditation Commission (URAC).			X
Arizona	A person is exempt from the provisions of this article if the person is accredited by the utilization review accreditation commission, the national committee for quality assurance or any other nationally recognized accreditation process recognized by the director.		X	X
Georgia	Any managed care entity or contractor providing utilization review services for a managed care plan may be deemed compliant by the Commissioner only if such entity or contractor is an applicant that has been accredited by URAC.			X
Illinois	No person may conduct a utilization review program in this State unless once every 2 years the person registers the utilization review program with the Department and certifies compliance with the Health Utilization Management Standards of URAC or AAAHC.	X		X
Minnesota	The MCO shall adopt a utilization management structure consistent with state and federal regulations and current NCQA "Standards and Guidelines for the Accreditation of Health Plans."		X	
Missouri	A health carrier may satisfy the requirements of section (1) by implementing the most recent utilization review program document it has submitted to either URAC or NCQA for certification, or to any similar entity.		X	X
Nebraska	Documentation that the applicant has received approval or accreditation by URAC, or a similar organization which has standards for utilization review agents that are substantially similar to the standards of URAC, and which has been approved by the director.			X
New Hampshire	Each person, partnership, or corporation licensed under this chapter shall adopt as the minimal acceptable standards for licensure either the URAC standards, the NCQA standards, or other similar standards acceptable to the commissioner.		X	X
North Dakota	However, the commissioner may find that the standards in this section have been met if the utilization review agent has received approval or accreditation by a utilization review accreditation organization.			
Pennsylvania	The application for a CRE shall contain evidence of approval, certification or accreditation received by a Nationally recognized accrediting body in the area of UR, if it has secured the approval, certification or accreditation.			
Rhode Island	Is certified by a nationally known health utilization management organization			
Tennessee	Utilization review programs for the mental health and chemical dependency care must comply with the most recent requirements of nationally recognized utilization review accrediting bodies.		X	X

State/Entity	Relevant Language (Utilization Management)	Accreditation Body		
		AAAHC	NCQA	URAC
Virginia	The program shall reflect the standards for utilization management from the most current NCQA Standards.		X	
Washington	Each carrier must establish and implement a comprehensive process for the review of adverse benefit determinations. The process must offer an appellant the opportunity for both internal review and external review of an adverse benefit determination. The process must meet accepted national certification standards such as those used by the National Committee for Quality Assurance, except as otherwise required by this chapter.		X	

Citations: Utilization Management

State/Entity	Citation
Alabama	http://www.alabamapublichealth.gov/mcc/assets/URLaw.pdf
Arizona	https://www.azleg.gov/viewdocument/?docName=http%3A%2F%2Fwww.azleg.gov%2Fars%2F20%2F02502.htm
Georgia	http://rules.sos.ga.gov/gac/120-2-80?urlRedirected=yes&data=admin&lookingfor=120-2-80
Illinois	http://www.ilga.gov/legislation/ilcs/fulltext.asp?DocName=021501340K85
Minnesota	https://mn.gov/dhs/assets/2020-fc-model-contract_tcm1053-413653.pdf
Missouri	https://www.sos.mo.gov/cmsimages/adrules/csr/current/20csr/20c400-10.pdf
Nebraska	https://nebraskalegislature.gov/laws/statutes.php?statute=44-5420
New Hampshire	http://www.gencourt.state.nh.us/rsa/html/xxxvii/420-e/420-e-mrg.htm
North Dakota	https://www.legis.nd.gov/cencode/t26-1c26-4.pdf
Pennsylvania	http://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/028/chapter9/s9.743.html&d=reduce
Rhode Island	http://www.eohhs.ri.gov/LinkClick.aspx?fileticket=Xg4aJSQkl_M%3d&portalid=0
Tennessee	https://bit.ly/3dsCFRM
Virginia	http://www.dmas.virginia.gov/files/links/2325/Final%20Expansion%20Amendment%20Medallion%204.0%20Contract%202018.pdf
Washington	https://apps.leg.wa.gov/wac/default.aspx?cite=284-43-3030

Other Endorsements

State/Entity	Relevant Language (Other Endorsements)	Accreditation Body		
		AAAHC	NCQA	URAC
HHS	This notice announces our decision to renew the Medicare Advantage ''deeming authority'' of URAC for health maintenance organizations and preferred provider organizations for a term of 6 years. (2019-2025)			X
California	If Contractor has received a rating of "Excellent", "Commendable", or "Accredited" from NCQA, the Contractor shall be "deemed" to meet the DHCS requirements for credentialing and will be exempt from the DHCS medical review audit of Credentialing. Deeming of credentialing certification from other private credentialing organizations will be reviewed by DHCS on an individual basis.		X	
District of Columbia	All MCOs must develop and maintain written policies and procedures for the credentialing and re-credentialing of all network providers to ensure the covered services are provided by appropriately licensed and accredited providers. These policies and procedures shall, at a minimum, comply with federal, state and NCQA standards.		X	
Louisiana	The Contractor shall provide LDH with written provider credentialing and recredentialing policies that are compliant with NCQA Health Plan Accreditation standards and all applicable state laws as part of readiness reviews and on an annual basis.		X	
Michigan	PCMH expansion to support Population Health 1. Contractor must contract with primary care practices that are recognized as Patient-Centered Medical Homes by National Committee for Quality Assurance (NCQA) or Blue Cross Blue Shield of Michigan Physician Group Incentive Program (PGIP), Utilization Review Accreditation Commission (URAC), Accreditation Association for Ambulatory Health Care (AAAHC) Medical Home, The Joint Commission (TJC) Primary Care Medical Home, Commission on Accreditation of Rehabilitation Facilities-Health Home (CARF), or under other PCMH standards approved by MDHHS.	X	X	X
Minnesota	The MCO shall adopt a uniform credentialing and recredentialing process and comply with that process consistent with state regulations and current NCQA "Standards and Guidelines for the Accreditation of Health Plans."		X	
New Jersey	The State Health Benefits Commission shall ensure that every contract purchased by the commission to provide benefits under the State managed care plans includes a disease and chronic care management plan for specified conditions meeting nationally recognized accreditation standards and including specified outcome measures and objectives for disease and chronic care management.			
North Carolina	Within one year of enrollment with Medicaid as a provider, the provider must have achieved national accreditation with at least one of the designated accrediting agencies.		X	
Oregon	Provider policies regarding credentialing practices of individual practitioners. The policies must reflect current credentialing standards as defined by nationally accepted accrediting bodies such as The Joint Commission, NCQA, and/or URAC;	X	X	

State/Entity	Relevant Language (Other Endorsements)	Accreditation Body		
		AAAHC	NCQA	URAC
Pennsylvania	Notwithstanding any other provision of this article to the contrary, the department shall give consideration to a managed care plan's demonstrated compliance with the standards and requirements set forth in the "Standards for the Accreditation of Managed Care Organizations" published by NCQA or other department-approved quality review organizations in determining compliance with the same or similar provisions of this article.	X		
South Carolina	Utilize the current NCQA Standards and Guidelines for the Accreditation of Medicaid Managed Care Organizations for the Credentialing and re-Credentialing of licensed independent Providers and Provider groups (i.e., Providers not associated with a delegated entity) with whom it contracts or employs and who fall within its scope of authority and action.			
Tennessee	The Contractor shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action. The Contractor shall develop and maintain a Population Health Program Strategy that meets or exceeds the NCQA standard PHM 1: PHM Strategy.		X	
Texas	Insurers will be presumed to be in compliance with statutory and regulatory requirements regarding credentialing if they have received nonconditional accreditation or certification by the NCQA, the Joint Commission, URAC, or AAAHC.	X	X	X
Virginia	The Contractor shall utilize credentialing and re-credentialing standards outlined by NCQA for network development and maintenance.		X	

Citations: Other Endorsements

State/Entity	Citation
HHS	https://www.govinfo.gov/content/pkg/FR-2019-05-21/pdf/2019-10586.pdf
California	https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx
District of Columbia	https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/DHCF%20Quality%20Strategy%20DRAFT%20%282%29.pdf
Louisiana	http://ldh.la.gov/assets/medicaid/RFP_Documents/RFP3/AppendixB.pdf
Michigan	https://www.michigan.gov/documents/contract_7696_7.pdf
Minnesota	https://mn.gov/dhs/assets/2020-fc-model-contract_tcm1053-413653.pdf
New Jersey	https://law.justia.com/codes/new-jersey/2013/title-52/section-52-14-17.29l/
North Carolina	https://files.nc.gov/ncdma/documents/files/12-B.pdf
Oregon	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=103214
Pennsylvania	https://www.legis.state.pa.us/WU01/LI/LI/US/PDF/1921/0/0284..PDF
South Carolina	https://msp.scdhhs.gov/managedcare/sites/default/files/2018%20MCO%20Contract%20-%20Amendment%20IV%20Final.pdf
Tennessee	https://www.tn.gov/content/dam/tn/tenncare/documents2/vshp.pdf

State/Entity	Citation
Texas	https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=28&pt=1&ch=3&rl=3706
Virginia	http://www.dmas.virginia.gov/files/links/2325/Final%20Expansion%20Amendment%20Medallion%204.0%20Contract%202018.pdf