What's in Health Plan Accreditation?

Understanding the Scope of NCQA's Health Plan Accreditation Program

NCQA developed the Health Plan Accreditation (HPA) program to provide an independent and unbiased review of health plan performance. HPA comprises a set of evidence-based requirements that build on three decades of experience measuring health plan quality. It ensures that plans have the processes, policies and procedures in place to deliver quality care, and it brings transparency to the outcomes they achieve across their network. HPA also provides employers with data to evaluate the performance of current and prospective health plans.

The HPA program evaluates health plans on:

- More than 100 elements across 6 categories. To earn Accreditation, plans must attain 80% of applicable points in each category.
- Outcomes achieved through annual reporting of HEDIS®[1] (the Healthcare Effectiveness Data and Information Set) and CAHPS®[2] (the Consumer Assessment of Healthcare Providers and Systems) data.

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[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

[2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

SIX CATEGORIES OF STANDARDS ENSURE PROCEDURES ARE IN PLACE TO DRIVE QUALITY

1. Quality Management and Improvement

- Does the health plan have quality improvement initiatives in place to monitor the quality, safety, continuity and coordination of clinical care, as well as the quality of service and members' experience?

- Do initiatives detail steps that will be taken to improve measures when needed?

- Does the plan collaborate with behavioral healthcare practitioners and have processes in place to monitor—and improve—coordination between medical and behavioral health providers?

- Does the plan monitor and take action as necessary to facilitate continuity and coordination of medical care across its delivery system?

2. Population Health Management

- Does the health plan have a comprehensive population health management strategy that details how it will:
  - o Keep members healthy?
  - o Manage members who have emerging risk?
  - o Improve patient safety or outcomes across settings?
  - o Manage members with multiple chronic illnesses?

- Does the plan leverage and integrate data from multiple services, such as medical and behavioral health claims, pharmacy claims, laboratory claims, EHRs, HA results and social determinants of health (SDOH), to assess the needs of its population and update its population health management activities as needed?

- Does the plan support its network by sharing member data, comparative quality data and evidence-based decision-making aids with providers?

- Does the plan offer value-based payments as a mechanism to drive quality improvement in its physician network?

- Does the plan's wellness and complex case management services assess a patient's SDOH, activities of daily living and cultural needs, while addressing clinical history?

3. Network Management

- Does the health plan provide and maintain an adequate and geographically disbursed network of primary, specialty and behavioral healthcare providers?

- Can members access care when it's needed—within an appropriate period—as measured by qualitative data (e.g., CAHPS or other survey data, complaints, etc.) or quantitative data (e.g., requests for utilization of out of network services)? Can members access follow-up care in an appropriate time?

- Does the plan provide physician and hospital directories to help members select providers, and does it evaluate and update the accuracy of the directories?

4. Utilization Management (Contains Two Must-Pass Elements)

- Does the health plan consistently apply objective, evidence-based criteria when determining the medical appropriateness of health care services?

- Does the plan have policies and procedures in place to ensure that coverage decisions are communicated with members and practitioners in a timely way and that members can access staff if they have questions about decisions?

- Does the plan use a physician or appropriate behavioral healthcare practitioner to review all behavioral healthcare denials of care based on medical necessity?

- Does the plan use a physician or pharmacist to review pharmacy denials?

5. Credentialing and Recredentialing (Contains Five Must-Pass Elements)

- Does the health plan verify physician credentials at least every three years to ensure member safety?

- Does the plan monitor practitioner sanctions, complaints and quality issues between recredentialing cycles and take appropriate action if it identifies occurrences of poor quality?

6. Member Experience

- Can members use the health plan's website to change providers, determine how and when to obtain referrals and determine financial responsibility for a specific service?

- Are the plan's website, phone and email communications accurate and easy to use/understand?

- Does the plan have processes in place for collecting, monitoring and timely review of complaints and appeals (unrelated to benefit decisions), and can it demonstrate that it follows up with members?

- Does the plan assess appeals, complaints, CAHPS survey or other data to identify opportunities for improving the member experience?

For more information, visit www.ncqa.org