

For Public Comment
November 5–December 17, 2018
Comments due 5:00 p.m. ET
December 17, 2018

Health Plan Accreditation Updates 2020 Overview

Health Plan Accreditation (HPA) 2020

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NCQA Customer Support: 888-275-7585

www.ncqa.org

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Health Plan Accreditation 2020 Updates Overview

Our Mission: Improve the Quality of Health Care

NCQA is dedicated to improving health care quality.

For almost 30 years, NCQA has been driving improvement throughout the health care system, helping to advance the issue of health care quality to the top of the national agenda. NCQA's programs and services reflect a straightforward formula for improvement: measurement, transparency, accountability.

This approach works, as evidenced by the dramatic improvements in clinical quality demonstrated by NCQA-Accredited health plans—health maintenance organizations (HMO), point-of-service (POS) organizations, preferred provider organizations (PPO)—using both standards and performance results. Today, approximately 181 million Americans are enrolled in a NCQA-Accredited health plan.

The NCQA Advantage

Proposed HPA updates aim to align standards with the changing market landscape, stakeholder (states, employers, CMS, consumer advocates) needs and regulatory requirements, and to assist organizations in their pursuit of quality care. The NCQA Accreditation seal is a sign to stakeholders—including employers, states and CMS—that organizations deliver high-quality care and have strong member protections.

Stakeholders Participating in Public Comment

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

NCQA asks respondents to consider whether the requirements are feasible as written, are clearly articulated, and to highlight areas that might need clarification.

Public Comment Global Questions

Public comment is integral to the development of all NCQA standards and measures. NCQA considers all suggestions. NCQA encourages reviewers to provide insights on global issues related to the proposed HPA updates:

- 1. Will the proposed HPA updates assist your organization in meeting its objectives? If so, how? If not, why not?
- 2. Are there key expectations not addressed in the proposed HPA requirements updates?

Targeted questions for proposed updates are included in the sections below.

Background and Objectives

For almost three decades, NCQA's Health Plan Accreditation standards and guidelines have been a quality improvement guide for new and established health plans. Coupled with HEDIS^{®1}/CAHPS^{®2} scoring, NCQA Health Plan Accreditation (HPA) pioneered the performance-based evaluation of quality of services and care delivered by plans.

HPA continues its evolution through changes that focus on:

- Improving the transparency in how NCQA evaluates and communicates plan performance.
- Emphasizing implementation of processes and achieving outcomes in Accreditation scoring.
- Reducing administrative burden for organizations undergoing Accreditation.

Evaluating and Communicating Health Plan Performance

Accreditation and Ratings Results

NCQA communicates plans' ratings on clinical quality, member experience and Accreditation survey results through two different products: the Health Plan Report Card (HPRC) and Health Plan Ratings (HPR).

- The NCQA HPRC³ lists the Accreditation statuses of commercial, Medicare, Medicaid and Marketplace health plans as Excellent, Commendable, Accredited, Provisional, or Denied (Excellent is highest, Denied is lowest). The report card also includes star ratings for five Accreditation-specific categories (Access and Service, Getting Better, Qualified Providers, Living With Illness, and Staying Healthy).
- The NCQA HPR⁴ is an annual report that rates health insurance plans in 0.5 increments on a scale of 0–5 (0 is lowest, 5 is highest)—a system similar to Medicare's Five Star Quality Rating System. As the ratings includes both Accredited and non-Accredited plans, the report lists which plans are NCQA-Accredited. The Report also shows ratings in three composites (Consumer Satisfaction, Prevention, Treatment) and detailed measure-level ratings.

While both reports are updated annually and use findings from HPA standards surveys and HEDIS and CAHPS results, they use similar-yet-different methodologies. These differences have the potential to cause scoring inconsistencies (e.g., a 5-point rating on HPR, but Commendable Accreditation status). Additionally, plans and stakeholders are often confused about the relationship between the Accreditation-status listed in the "Report Card" and health plan "Ratings," and the differences in evaluation methods.

NCQA seeks to alleviate confusion, consolidate evaluation methodologies and simplify reporting of plan performance.

Recommendations

- 1. Replace the similar-yet-different scoring methodologies used for Accreditation and HPR with a single scoring methodology and measures list (by product line) that produces one HEDIS/CAHPS score.
- 2. Use a single report card that displays results based on the single scoring system of 0–5 (in 0.5 increments) for the combined product. The rating will be represented by "stars" instead of a numerical result, for *all* plans. The new report card will display information as follows:
 - Plans that have earned NCQA Accreditation and annually submit HEDIS/CAHPS data to NCQA will have their status and Star-rating.

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

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

³https://reportcards.ncqa.org/#/health-plans/list

⁴http://healthinsuranceratings.ncqa.org/2018/Default.aspx

- Plans without NCQA Accreditation that submit HEDIS/CAHPS data to NCQA will have a star-rating and a "Not Accredited" designation.
- Plans that have earned NCQA Accreditation and but do not submit HEDIS/CAHPS data to NCQA will have a status and a designation that performance on HEDIS/CAHPS is not available.

<u>Figures 1</u> shows how a future health plan Report Card might combine plan Accreditation-status and a star rating.

Search this list, enter keyword SEARCH **Filters** STATE SERVED STATES PRODUCT A INSURANCE 4 HEALTH PLAN NAME ACCREDITATION (RATING 🛊 SERVED TYPE INSURANCE TYPE Example Health Plan 1 SC Medicare нмо Accredited PRODUCT TYPE Example Health Plan 1 Provisional SC Medicaid нмо ACCREDITATION Example Health Plan 2 DC Medicaid нмо RATING Interim - Standards Only Submitted No Data Example Health Plan 3 MD Medicaid нмо Submitted Example Health Plan 4 Not Accredited * * 4 4 4 4 нмо Example Health Plan 5 нмо

Figure 1: Future Health Plan Report Card Draft

Scoring and Benchmarking Data

Provisional

Accredited - Under Corrective Action

Historically, HPA developed the initial benchmark for Accreditation scoring based on prior years' data and updates the benchmarks mid-year (after HEDIS data submission) for measures with trending concerns, to account for the newest data. This allows plans to have advance notice of the rates they will be scored against, while holding them accountable for newer data for measures that have had significant updates.

WA

Medicaid

нмо

HPR uses the most current data released each July to calculate thresholds and score plans.

Recommendation

Example Health Plan 6

Example Health Plan 7

Develop and communicate the initial benchmarks/percentiles based on prior years' HEDIS/CAHPS data but will update the initial benchmarks (not just those with trending concerns) and score plans against the most current data that are received in June for all measures. This will allow organizations to receive advanced notice of the benchmarks/percentiles for scoring while also allowing the use of the most current data for the scoring component. NCQA does not typically see much change in the aggregated data from one year to the next for measures that did not have any specification changes.

Targeted Questions

- 1. Do you support the recommendation to replace the similar-yet-different scoring methodologies used for Accreditation and HPR with a single scoring methodology?
- 2. Do you support the recommendation to have a single report card that utilizes star ratings?
- 3. Do you support NCQA's recommendation to communicate the initial benchmarks based on prior years' HEDIS/CAHPS data, but update the initial benchmarks and score plans based on the most current data that are received in July for all measures?
- 4. Do you support the recommendation to give overall Accreditation bonus for all Accredited plans and eliminate all other bonuses and adjustments?
- 5. What information should be included in the new report card (refer to <u>figure 1</u>, which provides a mock-up of the future report)?

Note: NCQA will be holding a separate public comment in January 2019, outlining concepts to modernize our HEDIS/CAHPS performance scoring methodology for Health Plan Ratings. We anticipate this effort will impact the way NCQA sets cut points (scoring percentiles) for measures.

HEDIS/CAHPS Update for Scoring

This public comment seeks feedback on proposed measure changes for the combined Health Plan Ratings and Health Plan Accreditation scoring measure list.

A critical issue for any quality rating tool is the certainty of the judgment—we want to be sure that plans assigned a higher value deserve it. If a rating system includes redundant measures or measures with poor statistical properties, we risk rewarding random variation (noise) over true quality differences (signal).

Measure Selection Criteria

All HEDIS and CAHPS measures eligible for use in NCQA programs were reviewed against the following selection criteria:

1. Measure exhibits desirable statistical properties.

- Reliable. A reliable measure is permits statistical differentiation of one plan from the overall pattern of performance across plans. With higher reliability, we are less likely to make a mistake on a performance rating.
- Room to improve. If all plans perform at a very high level, there is little reason to push for higher performance. We set this criterion as average performance of less than 90%.
- Exhibits meaningful variation. The more variation in performance, the more certain we can be that a plan is high performing. And if most plans score above 90%, it becomes harder to distinguish the best performers from the next-best performers. Based on prior experience working with the measures, we defined a ≥15% difference between the 10th and 90th percentiles as meaningful variation.
- Consistently scoreable. If a measure is scoreable one year but not scoreable the next, then year-to-year variation in the overall score reflect changes in the measures used, rather than plan performance. At least 40% of plans must have a scoreable rate: The plan reports a valid rate (e.g., the auditor says it is valid and between 0% and 100% performance) or the plan fails to submit (not reported or a biased rate, receiving a 0 on the rating scale) to support accountability for reporting accurate data. We continue to exempt plans that have small sample sizes or absence of benefit, because not having a valid rate is not under the plan's control.

2. Use in programs and strategic trends.

NCQA considered a measure's use in external programs (e.g., Star Ratings, Medicaid core set), performance trends (e.g., declining performance) and strategic objectives (e.g., reward for reporting ECDS depression measures).

Measures address quality of health care practices or patient experience of health care practices. This criterion eliminated Health Plan Descriptive Information measures (neither quality nor patient experience) and most Use of Services measures that do not apply risk adjustment (no optimal volume of services without reference to a case mix adjusted population).

3. Eliminate redundancy between paired measures.

- For "paired" measures (e.g., testing and control of HbA1c in *Comprehensive Diabetes Care*; *Initiation and Engagement of Alcohol and Other Drug Abuse Dependence Treatment*), choose the measure closest to the ultimate clinical outcome. Control is the clinically more important metric. For example, everyone in the control measure was tested by definition, and so the testing measure does not add new information. In the drug abuse measure, everyone who is "engaged" in treatment was also "initiated," and if the ultimate outcome of treatment is remission or abstinence, engagement is closer to the outcome in the sequence from identification to successful treatment.
- Eliminate measures that do not add information to distinguish plans. For example, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents has three measures—recorded BMI, advising on nutrition, advising on physical activity—that are correlated at over 98%. The differences between plans on who provides either counseling service is not distinguishable from random chance. We selected BMI because it is the "outcome" upon which the provider must act, and how a plan does on BMI is almost exactly how it performs on counseling.

Recommendation

Add the following new measures for the commercial, Medicare and Medicaid product lines.

	Measure	Commercial	Medicare	Medicaid
DAE	Use of High-Risk Medications in the Elderly—Rate 2 Only		✓	
FUM	Follow-Up After ED Visit for Mental Illness—7-Day Rate	✓	✓	✓
FUA	Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence—7-Day Rate	✓	√	✓
MRP	Medication Reconciliation Post-Discharge		✓	
TRC	Transitions of Care—All Four Rates		✓	
FMC	Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions		√	
UOD	Use of Opioids at High Dosage	✓	✓	✓
UOP	Use of Opioids from Multiple Providers—Multiple Prescribers and Multiple Pharmacies Rate	✓	✓	✓
AHU	Acute Hospital Utilization	✓	✓	
HPC	Hospitalization for Potentially Preventable Complications		✓	
FRM	Fall Risk Management		✓	
ОТО	Osteoporosis Testing in Older Women		✓	

Retire the following measures for the commercial, Medicare and Medicaid product lines.

	Measure	Commercial	Medicare	Medicaid
DAE	Use of High-Risk Medications in the Elderly—Rate 1 Only		✓	
NA	CAHPS Customer Service	✓	✓	✓

Please refer to <u>Appendix 4: HEDIS/CAHPS Measure List</u> for the rationale for measure inclusions and retirements.

Targeted Questions

- 6. Do you support NCQA's recommendation to add the proposed HEDIS measures to HPR/HPA scoring in reporting year 2020? If no, which measures should be excluded, and why?
- 7. Do you support NCQA's recommendation to retire the proposed HEDIS measures for HPR/HPA scoring in reporting year 2020? If no, which measures should remain in the measure set, and why?
- 8. Do you support NCQA's recommendation to retire the proposed CAHPS measure for HPR/HPA scoring in reporting year 2020? If no, and why?

Refer to Appendix 4 for Proposed Measure Set Changes.

Note: Comments can be entered for each product line-specific measure in the public comment database.

HPA 2020 Standard Changes Recommendations

Retiring Requirements

As innovations and public policy change the health care landscape, NCQA recognizes the need for the HPA product to evolve. In the 27 years since the launch of Accreditation, there has been a gradual increase in the number of requirements on which plans are evaluated. In HPA 2019 there are 160 non-delegation elements consisting of 617 factors.

To address the transforming market and reduce plan burden in achieving and maintaining Accreditation, NCQA recommends retiring 25 elements, consisting of 106 factors, and 7 individual factors across remaining elements. Refer to <u>Appendix 1: Recommendations for Elements Retirement for HPA 2020</u> for a list of requirements proposed for retirement, and the rationale.

Targeted Questions

9. Do you support NCQA's recommendation to retire the proposed elements and factors as described in Appendix 1? If no, why not?

Note: Comments can be entered for each element in the public comment database.

Reorganizing Standards and Elements

To improve flow and organization of the remaining standards and elements, NCQA recommends the remaining standards be regrouped into the following categories:

QOG Quality Oversight & Governance

This category of standards might look new because of its title, but it is composed of existing requirements related to all major programs delivered by plans, including QI program structure, PHM strategy, UM program structure and credentialing policies.

PHM Population Health Management

This category of standards remains largely unchanged, except that PHM 1: PHM Strategy now lives in Quality Oversight & Governance.

NET-CR Network Management & Credentialing

This category of standards captures plans' activities related to health care delivery, including access and availability of practitioners, accuracy of practitioner and provider directories, continuity and coordination of medical and behavioral healthcare and practitioner and facility credentialing.

UM Utilization Management

This category of standards remains largely unchanged, except that UM 1: Utilization Program Structure and UM 2: Clinical Criteria for UM Decisions now live in Quality Oversight & Governance.

ME Member Experience

This category of standards combines all member-facing health plan customer support functions from the current standards for Members' Rights and Responsibilities (RR) and Member Connections (MEM)

Refer to Table 4. List of Standard Categories and Elements (page 17) for a detailed list of elements in each category.

Targeted Questions

10. Do you support NCQA's proposed order of standards and elements? If no, why not?

Note: Comments can be entered for each category of standards in the public comment database.

Recommendation: Improve Clarity and Surveyability

NCQA recommends updating elements related to member experience and network adequacy to improve the clarity and surveyability of these requirements and remove duplication with other requirements.

• RR 2, Element A: Policies and Procedures for Complaints

Revise factors 2 and 4 to remove "clinical care" and "clinically urgent situations," as these
references sometimes are interpreted as UM-related issues. This process is for any complaint that
does not become a request for service and does not go through the UM process.

• RR 2, Element B: Policies and Procedures for Appeals

- Update the element stem to include appeals "of decisions that are not about coverage." This is an existing requirement. The update helps to clearly distinguish appeals in this element from appeals for coverage assessed in UM 8: Policies for Appeals and UM 9: Appropriate Handling for Appeals.
- Revise factors 2 and 4 to address the same issues stated for RR 2. Element A.

• QI 4, Element C: Annual Assessment

- Revise the element title to state "Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals." This title reflects the requirement intent more accurately.
- Restructure the element to include requirements in the stem (eliminate the factors). Currently, organizations can receive credit for collecting data without analyzing the data.

QI 4, Element E: Annual Assessment of Behavioral Healthcare and Services

 Add "for each of the five required categories" to factor 1. This existing expectation is found in the explanation. The update aligns with the element structure for nonbehavioral healthcare assessment (QI 4, Element C).

• NET 3, Element A: Assessment of Member Experience Accessing the Network

- Plans find this requirement to be duplicative with the data collection and assessments required in QI 4: Member Experience. To address this issue, NCQA proposes to restructure NET 3, Element A to indicate that plans need to use analysis already conducted in QI 4: Member Experience to identify network gaps.
- Add a new factor 4 to allow a separate assessment of behavioral requests for and utilization of out-of-network services. This is not a new requirement. Currently assessment of behavioral and nonbehavioral out-of-network requests is combined in factor 3, which poses challenges for scoring and automatic credit. Additionally, it is important to track and see the data separately: A recent Milliman report found significantly higher rates of out-of-network use for behavioral healthcare, compared with medical/surgical care.⁵
- Review this element for each product line brought forward for accreditation.
- Remove the Marketplace product line exception; NCQA proposes to retire the corresponding Marketplace-specific element NET 4C: Marketplace Member Experience.

• NET 3, Element B: Opportunities to Improve Access to Nonbehavioral Healthcare Services, Element C: Opportunities to Improve Access to Behavioral Healthcare Services

- Update factor 1 to reference the updated sources plans need to use to prioritize opportunities for improvement.
- Review this element for each product line brought forward for Accreditation.
- Remove the Marketplace product line exception; NCQA proposes to retire the corresponding Marketplace-specific element NET 4C: Marketplace Member Experience. The look-back period for Marketplace will be adjusted to reflect that opportunities for improvement is a new expectation.
- Change references to "nonbehavioral healthcare services" with "physical health services," where appropriate, in HPA 2020.

Targeted Question

- 11. Do you support NCQA's recommendation update the elements as proposed above?
- 12. NCQA recommends changing references to "nonbehavioral healthcare services" with "physical health services" where appropriate. Do you support this recommendation?

Note: Comments can be entered for each element in the public comment database.

⁵http://www.milliman.com/uploadedFiles/insight/2017/NQTLDisparityAnalysis.pdf

Calculating and Reporting Standards Results

Plans currently receive the same standard score for all product lines brought forward for Accreditation; where there are differences in product line performance, scores are averaged. Plans must submit evidence by product line for seven elements (e.g., QI 4, Element C: Annual Evaluation); for the remaining elements plans only submit evidence by product line if they perform the function differently.

Stakeholders want more-detailed performance results; for example, states want details about managed care plan performance on UM file review for Medicaid product lines. The current method of averaging results does not give them that information.

In some cases, plans find it unfair that because of averaging, poor performance on one product line affects the accreditation status across all product lines under review. This impact is greater since the scoring threshold for UM file review elements was increased to 80% and above in HPA 2019. If a plan does not score 80%—or 100%, in some cases—on UM file review elements, all product lines are affected by a lower status, a Corrective Action Plan and a Report Card marker to indicate the deficiency.

Recommendation

NCQA proposes to calculate and report standards results by product line (line of business: commercial, Medicare, Medicaid, Marketplace). NCQA will continue to review elements by product line in the following scenarios:

- 1. The organization administers the product lines differently.
- Elements required by NCQA, whether or not the organization administers its product lines the same way. In addition to the existing set of elements always reviewed by product line, NCQA recommends adding:
 - NET 3: Assessment of Network Adequacy
 - All UM file review elements

Targeted Questions

- 13. Do you support NCQA's recommendation to add the elements in NET 3: Assessment of Network Adequacy to the list of those we always review by product line? If no, why not?
- 14. Do you support NCQA's recommendation to review all UM File Review elements by product line? If no, why not?

Note: Comments can be entered for each element in the public comment database.

Strengthening UM File Review Rigor

Along with scoring UM file review elements by product line, NCQA also recommends changes to the approach to evaluating timeliness of notification of initial UM decisions and appeals. Recent findings (from the HHS Office of the Inspector General) about Medicare Advantage appeal outcomes and audit findings indicate that members are being denied care they should receive. Although HPA's UM file review requirements are designed to detect this type of occurrence, NCQA believes that updates will strengthen them. Additionally, recent reportable events investigations conducted by NCQA identified fraudulent date changes associated with utilization management activities, which is a risk to organizations that may delegate UM activities.

⁶https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf

Recommendation

As described in the *Calculating and Reporting Standards Results* section, a separate file review will be conducted for each product line brought forward for Accreditation for all UM file review elements. This will increase (statistical) confidence that the performance observed is applicable to each accredited product line.

In addition, NCQA proposes to:

- 1. Change the data source from "file review" to "electronic data reporting" and set a 90% compliance threshold for the following must-pass elements:
 - UM 5:
 - Element B: Notification of Nonbehavioral Decisions.
 - Element D: Notification of Behavioral Healthcare Decisions.
 - Element F: Notification of Pharmacy Decisions.
 - UM 9, Element B: Timeliness of the Appeal Process.

These elements require plans to adhere to specific timeframes for four different types of decisions: urgent concurrent, urgent preservice, non-urgent preservice, postservice. To meet the compliance threshold, the organization must demonstrate that it meets the time frames for notifying members for 90% of each aforementioned decision type for each product line.

2. Add a new element in UM titled *Data Validation* to confirm the integrity of the data plans submit for electronic data reporting.

The proposed approach standardizes data collection and data elements required for reporting and would replace *UM 5, Element G: Timeliness Report*, which does not include data collection specifications.

To meet the updated requirements for notification of initial UM decisions and appeals, plans will have to submit the full universe of decisions by product line, including decisions processed by delegates. NCQA will provide specifications and calculate turnaround time results using algorithms that consider factors associated with turnaround time compliance. NCQA will implement audit and validation processes to promote data integrity. Refer to <u>Appendix 3: UM Notification of Decisions Recommendations</u> for details.

The proposed changes will result in the following benefits:

- Strengthened UM requirements through expanded evaluation to a plan's full universe of UM files (not a sample).
- Efficient calculation of scoring results for each line of business.
- Improved reliability of results through defined data definitions, and improved reporting, system specifications and data validation processes.

NCQA sought feedback on the feasibility of this concept with several health plan customers and shared draft specifications for the electronic data report. Although the majority of those contacted supported the increased and improved UM rigor of turnaround time compliance evaluation through electronic data reporting, feedback suggested NCQA should:

- 1. Provide a **phased in approach** to evaluation. Options to consider include having plans:
 - Develop an implementation plan during 2020 with data submission beginning in 2021.
 - Voluntarily report in 2020 for data evaluation and calculation of timeliness results, without negative impact to element scores if the results fall below the 90% threshold.
 - Submit data as a requirement (not voluntary) in 2020 without impact to standards scoring until 2021. This would ensure the NCQA has enough data for analysis purposes.

Note: Plans will continue to be reviewed via file review in 2020.

- 2. Provide sufficient time for organizations to evaluate and make any necessary enhancements to operational systems to provide required data (18 24 months).
- 3. Consider having plans calculate and submit turnaround time results instead of raw data.

Targeted Questions

- 15. Electronic reporting specifications are outlined in <u>Appendix 3</u>. Do you support NCQA's use of electronic data to calculate timeliness of UM notifications? If no, why not?
- 16. Does your organization use any additional data to calculate turn around time for UM? If so, please provide the data fields used and impact to the turn around time calculation.
- 17. Do you support NCQA calculating the turn around time through submission of a full universe report? If no, why not?
- 18. Do you support a phased-in approach (see options outlined above) to scoring? If yes, please indicate which option or combination of options you prefer?

Accreditation Scoring and Status Determination

Currently, a plan's combined HEDIS, CAHPS and standards score is used to determine Accreditation status. Under the current scoring rubric, standards are worth 50 points and HEDIS/CAHPS measures are worth 50 points. The more points that are earned, the higher the plan's status. NCQA would like to continue using both performance against the standards and HEDIS/CAHPS measures to determine Accreditation. However, under the single scoring methodology proposed previously, plans will receive a Star-rating to denote performance on HEDIS/CAHPS rather than points. Consequently, the methodology used to score the Standards portion of Accreditation will need to be updated to continue to incent plans to maintain a high-level of performance across the standards. Additionally, how the standards score will be combined with Ratings will need to be updated to support a single, transparent assessment and report of plan performance.

Recommendation

- 1. **Element Scoring.** NCQA proposes to eliminate points and replace element scoring levels with three options:
 - Met: Equivalent to the 80%–100% scoring thresholds today.7
 - Partially Met: Equivalent to the 50% scoring threshold.
 - Not Met: Equivalent to the 0%–20% scoring thresholds.

Reducing the scoring levels to 3 improves clarity and provides greater transparency about health plans' compliance on the standards. This type of scoring closely aligns with how states evaluate plan performance against Medicaid Managed Care Rules and how CMS evaluates Medicare Advantage plans. Plans will be able to demonstrate and communicate to states and other purchasers how they perform on the standards.

- 2. **Determining Accreditation Status.** For HPA 2020 and beyond, NCQA proposes that Accreditation be based on:
 - Standards and guidelines: The percentage of elements "met" in each category of standards (e.g., Utilization Management), rather than a number of points, **and**
 - HEDIS/CAHPS measures: A star rating (0–5) based on the new Health Plan Ratings methodology and measures. Plans will need to meet a minimum Star rating threshold (e.g., 2.5) to maintain Accredited status. The following thresholds and impacts to status are being considered:

⁷Exceptions will apply. For example, to earn "met", organizations will need to score all factors.

- Plans must have a minimum of a 2.5-Star rating to achieve Accredited status.
- Plans with a rating below 2.5 Stars for two consecutive years will have Provisional Status.
- Accreditation may be denied if a plan has a rating below 2.5 Stars for three consecutive years.

Because NCQA is proposing to move to a single methodology for evaluation and communicating plan performance, "Commendable" and "Excellent" status will be eliminated. There will be three Accreditation statuses for plans undergoing First and Renewal Surveys: Accredited, Provisional and Denied Accreditation. Plan performance will be communicated via their status plus Star-rating, (e.g., Accredited, 5 Stars rather than "Excellent").

Moving away from points across the entire set of standards and setting a threshold for each standard category provides a more precise level of expectations for performance on the standards. While each element will be worth the same, existing scoring rules can be used to distinguish the relative importance of requirements without unintentionally incentivizing plans to focus on requirements that may be of lower-value to their populations:

- Designate elements as "must-pass": An organization must score "met" on the element. If not, the organization will be under Corrective Action until the issue is resolved.
- Designate "critical factors": An element cannot be "met" unless the factor is met.

<u>Table 1</u> provides a summary of how Accreditation status could be determined based on the proposed scoring changes.

Table 1. Accreditation Status Scoring Criteria

Status	Scoring Criteria				
Accredited	Meets the HEDIS/CAHPS threshold and				
	• 80% or more "met" elements, including Must-Pass elements and				
	No more than 10% "not met" elements				
Provisional	Does not meet the HEDIS/CAHPS threshold and/or				
	• 70%-79.9% "met" elements and/or				
	11%-19.9% "not met" elements and/or				
	Fails 3 or more Must-Pass elements				
Denied Accreditation	Does not meet the HEDIS/CAHPS threshold and/or				
	69.9% or less "met" elements and/or				
	Over 20% "not met" elements and/or				
	Fails 3 or more UM timeliness Must-Pass elements				

Accredited status is valid for three years and is verified annually, based on performance against HEDIS/CAHPS.

Provisional status is temporary; it lasts up to 18 months while the plan corrects deficiencies.

Plans that are Denied Accreditation may reapply for Accreditation at any time.

<u>Table 2</u> outlines the thresholds that would need be met in each category of standards under the proposed scoring changes (refer to Table 4 on page 17 for the full list of requirements). In this example, if the plan earns a score of "not met" for two or more elements in the Population Health Management category, but has no other deficiencies, it earns Provisional status.

Table 2. Example of Standards Scoring

Standard Category	Total Number of Elements	Minimum to Meet in Each Category With an 80% Threshold	Maximum That Can be Missed in Each Category
Quality Oversight & Governance	8	7	0
Population Health Management	10	8	1
Network Management & Credentialing	20	16	2
Utilization Management	29	24	2
Member Experience	11	9	1

Targeted Questions

- 19. Do you support NCQA's recommendation for changing the scoring levels to 3 levels (met/partially met/not met)? If no, why not?
- 20. Do you support NCQA's recommendation to set thresholds for percentage of elements that must be met for each category of standards to determine Accreditation status rather than the current proportion of 50-points scoring method? If no, why not?
- 21. Other than the use of must-pass elements and critical factors, do you believe there are other mechanisms that should be used to put more relative weight on some elements vs. others? If yes, please explain. Please provide examples of specific elements you believe should have heavier weight.
- 22. Are there unintended consequences of not using a point-structure that are not addressed in this overview?

Evaluation Options

Evaluation Options are defined by a distinct combination of requirements (standards and measures), scoring, statuses and length of Accreditation. HPA has three Evaluation Options:

- 1. Interim.
- 2. First.
- 3. Renewal.

The Interim and First Evaluation Options are used by accreditable entities new to NCQA; the Renewal Evaluation Option is for plans with current Accreditation.

Renewal Evaluation Option

Organizations with current NCQA Accreditation come through the Renewal Evaluation Option every three years and are reviewed on the full set of requirements. Under HPA 2019, this is 160 elements— or 617 factors.⁸ Over the years, customer organizations and surveyors have indicated that this ongoing review of an ever-growing number of requirements has become burdensome and challenging.

⁸This count excludes delegation elements and elements in the distinction modules.

Recommendation

NCQA recommends the following changes to address these concerns:

- 1. Retire elements and/or factors as described in the previous section.
- 2. Restructure the Renewal Evaluation Option to require a review of outcome-related requirements.

Approximately 90% of plans undergoing Renewal will be eligible to submit evidence for a smaller set of requirements that will include all file review, must-pass and other elements focused on implementation of important functions and key consumer protections. The smaller set of requirements represents a 48% reduction in the number of elements that will be reviewed, compared with requirements in an HPA 2019 Renewal Survey.

Note: Plans eligible for this streamlined Renewal option are expected to attest that they maintain activities and documents for requirements not being reviewed and must be able to provide them during their survey, if requested.

The remaining plans (~10%) will be reviewed against the full set of requirements if selected during the annual systematic sampling process or if they voluntary opt-in for this type of review. Selected plans will be notified when they apply (9–10 months before the survey date).

Systematic Sampling Process. During the annual selection of plans, NCQA will use a systematic sample selection methodology to ensure that large corporate plan families (e.g., UnitedHealthcare) are not over-represented or selected more frequently than unaffiliated organizations (e.g., small regional plan). This approach draws equal sample sizes from each family of plans, regardless of the family's size. Sampling intervals are set separately for each family and there is a randomized starting point during annual selection.

Refer to <u>Table 4. Standard Categories and Elements</u> (page 17) for the proposed set of elements that will be reviewed vs. attested to for Renewal.

3. Update QI 1, Element A: Program Structure and UM 2, Element A: UM Criteria. Factors in both elements require documented process and reports/materials. To reduce plan burden and allow "cleaner" scoring, NCQA recommends splitting these elements as follows:

Table 3. Standards Updates

Element Title and Factors	Data Source	Renewal
QOG 1, Element A: Program Structure (factors 1-5, 7)	Documented process	Attest
QOG 1, Element B: Annual Work Plan (factor 6)	Reports	Submit evidence
QOG 3, Element C: UM Criteria Policies (factors 1-3)	Documented process	Attest
QOG, Element D: UM Criteria Implementation (factors 4–5)	Reports, materials	Submit evidence

Refer to Appendix 2: HPA 2020 Marked-Up Standards for standard revisions.

Targeted Questions

- 23. Do you support NCQA's recommendation to update the elements as proposed in <u>Table 3</u> (refer to <u>Appendix 2</u> for standards language)?
- 24. Do you support NCQA's recommendation for the elements that will be reviewed with documentation and for those that attestation is allowed (refer to <u>Table 4</u> on page 17 for a full list of elements)? Are there any elements that should be added or removed for review or attestation?

Current Interim Evaluation: Glidepath to Accreditation

The Interim Evaluation Option was introduced in HPA 2013 to accommodate Marketplace products offered by new plans or plans that were already NCQA Accredited rather than continuing to offer a separate "New Health Plan" Accreditation product. The Affordable Care Act requires organizations that offer Marketplace products to be accredited; NCQA is a CMS-approved accreditor. Because these products were new to the market, they were not required to report HEDIS/CAHPS measures.

Currently, plans new to NCQA may start their Accreditation journey with the Interim Evaluation Option, which consists of a smaller set of elements that focus on policies and procedures. New health plans typically seek this option, earning "Interim Accreditation," which lasts up to 18 months.

A plan then goes to the First Evaluation Option, which consists of the full set of Accreditation requirements. Plans that selected the Interim Option are not required to submit HEDIS/CAHPS measure results. Plans undergoing a First Survey are not required to submit HEDIS/CAHPS results until the third annual HEDIS reporting cycle during their Accreditation. Thus, plans going through an Interim Survey, followed by a First Survey, can delay reporting of HEDIS/CAHPS for more than four years.

Recommendations

- 1. NCQA recommends changes to the Interim glidepath to Accreditation to include a two-part survey:
 - Part 1: The organization is reviewed against the current set of requirements in the current Interim Evaluation Option (policies and procedures). The organization earns Interim status for up to 18 months and applies for Part 2 before this status expires.
 - Part 2: The organization is reviewed against the remainder of the HPA requirements (file review elements; elements requiring analyses and reports), along with requirements on which the plan did not perform well during the initial survey. The plan earns "Accredited" status, which lasts up to 36 months from the initial survey accreditation decision.
 - This update saves plans time as they will not have to re-submit policies and procedures that were recently reviewed and allows them to focus on quality improvement activities and systematic implementation of their policies.
- NCQA recommends changes to the timing of HEDIS/CAHPS reporting for plans new to NCQA Accreditation:
 - Report HEDIS/CAHPS in the calendar year following the effective date of their Accreditation status if they meet reporting requirements (e.g., 15,000-member threshold). For example, a plan whose Accreditation status becomes effective in January 2021 will report HEDIS/CAHPS in June 2022 and will be scored annually on HEDIS/CAHPS beginning in June 2023.
 - NCQA is considering allowing more time for reporting for plans that are accredited on or after July 1. For example, if a plan whose Accreditation status becomes effective in August 2021 will report HEDIS/CAHPS in June 2023.

This update aligns with state and CMS requests for faster integration of HEDIS/CAHPS reporting for Accreditation.

Targeted Questions

- 25. Do you support NCQA's recommendation to change the Interim glidepath to a two-part survey? If no, why not?
- 26. Do you support NCQA's recommendation to require plans new to NCQA to report HEDIS/CAHPS in the proposed timeframe?

Changes to the Survey Process

As part of HPA Refresh, NCQA proposes updates to the survey process and systems to improve plans' experience with the Accreditation process:

- Single Application and Survey Tool. National organizations and organizations that come through the single-site multiple-entity (SSME) product must currently fill out and submit multiple survey applications and tools every survey cycle. NCQA will develop a single tool for the national organizations and a single tool interface for the SSME-product type that will significantly reduce the number of hours spent on administrative tasks related to surveys.
- Online Application Integration. System changes will provide access to the application through IRT instead of in a separate portal.

Table 4: Standard Categories and Elements

Element	Renewal	First	Interim
QUALITY OVERSIGHT AND GOVERN	IANCE (QOG)		<u>'</u>
QOG 1: Program Structure and Operations (formerly QI 1 and QI 2, Elem	ent B)		
Element A: QI Program Structure (formerly QI 1, Element A)	Attest ⁹	√ 10	✓ Part 1
Element B: Annual Work plan (formerly QI 1, Element A, factor 6)	✓	✓	✓Part 2
Element C: Annual Evaluation (formerly QI 1, Element B)	✓	✓	✓Part 2
Element D: QI Committee Responsibilities (formerly QI 2, Element A)	✓	✓	✓ Part 1
QOG 2: PHM Strategy (formerly PHM 1)			
Element A: Strategy Description (formerly PHM 1, Element A)	✓	✓	✓ Part 1
Element B: Informing Members (formerly PHM 1, Element B)	Attest	✓	✓ Part 1
QOG 3: Utilization Program Structure & UM Decisions (formerly UM 1, U	M 2)		
Element A: Written Program Description (formerly UM 1, Element A)	Attest	✓	✓ Part 1
Element B: Annual Evaluation (formerly UM 1, Element D)	✓	✓	✓Part 2
Element C: Policies for UM Criteria (formerly UM 2, Element A, factors 1-3)	Attest	✓	✓ Part 1
Element D: UM Criteria Maintenance (formerly UM 2, Element A, factors 4-5)	✓	✓	✓Part 2
Element E: Availability of Criteria (formerly UM 2, Element B)	Attest	✓	✓ Part 1
Element F: Consistency in Applying Criteria (formerly UM 2, Element C)	✓	✓	✓ Part 2
QOG 4: Credentialing Policies & Committee (formerly CR 1, CR 2)	<u>.</u>		
Element A: Practitioner Credentialing Guidelines (formerly CR 1, Element A)	Attest	✓	✓ Part 1
Element B: Practitioner Rights (formerly CR 1, Element B)	Attest	✓	✓ Part 1
Element C: Credentialing Committee (formerly CR 2, Element A)	✓	✓	✓ Part 1
QOG 5: Delegation (formerly QI 7)			
Element A: Delegation Agreement (formerly QI 7, Element A)	✓	✓	✓ Part 2
Element B: Predelegation Evaluation (formerly QI 7, Element B)	✓	✓	✓ Part 2
Element C: Review of QI Program (formerly QI 7, Element C)	✓	✓	✓ Part 2
Element D: Opportunities for Improvement (formerly QI 7, Element D)	✓	✓	✓ Part 2
POPULATION HEALTH MANAG	EMENT		
PHM 1: Population Identification (formerly PHM 2)			
Element A: Data Integration (formerly PHM 2, Element A)	✓	✓	✓ Part 1
Element B: Population Assessment (formerly PHM 2, Element B)	✓	✓	✓ Part 1
Element C: Activities and Resources (formerly PHM 2, Element C)	✓	✓	✓ Part 1
Element D: Segmentation (formerly PHM 2, Element D)	✓	✓	✓ Part 1

⁹ Organizations attest to maintaining required activities but do not submit evidence in the Interactive Review Tool (IRT) for surveys. ~10% of plans will annually be required to submit evidence for elements designated with "attest."
¹⁰Organizations are required to submit evidence for elements designed with a check-mark.

Element	Renewal	First	Interim
PHM 2: Delivery System Updates (formerly PHM 3)			'
Element A: Practitioner or Provider Support (formerly PHM 3, Element A)	√ 11	✓	✓ Part 1
Element B: Value-Based Payment Arrangements (formerly PHM 3, Element B)	~	✓	✓ Part 2
PHM 3: Wellness and Prevention (formerly PHM 4)			
Element A: Frequency of Health Appraisal Completion (formerly PHM 4, Element F)	Attest ¹²	✓	✓ Part 2
Element B: Topics of Self-Management Tools (formerly PHM 4, Element H)	Attest	✓	✓Part 2
PHM 4: Complex Case Management (formerly PHM 5)			
Element A: Access to Case Management (formerly PHM 5, Element A)	Attest	✓	✓ Part 1
Element B: Case Management Systems (formerly PHM 5, Element B)	Attest	✓	✓ Part 1
Element C: Case Management Process (formerly PHM 5, Element C)	Attest	✓	✓ Part 1
Element D: Initial Assessment (file review) (formerly PHM 5, Element D)	✓	✓	✓ Part 2
Element E: Case Management—Ongoing Management (file review) (formerly PHM 5, Element E)	✓	✓	✓ Part 2
PHM 5: Population Health Management Impact (formerly PHM 6)			
Element A: Measuring Effectiveness (formerly PHM 6, Element A)	✓	✓	✓Part 2
Element B: Improvement and Action (formerly PHM 6, Element B)	✓	✓	✓Part 2
PHM 6: Delegation of PHM (formerly PHM 7)			
Element A: Delegation Agreement (formerly PHM 7, Element A)	✓	✓	✓ Part 2
Element B: Predelegation Evaluation (formerly PHM 7, Element B)	✓	✓	✓ Part 2
Element C: Review of PHM Program (formerly PHM 7, Element C)	✓	✓	✓ Part 2
Element D: Opportunities for Improvement (formerly PHM 7, Element D)	✓	✓	✓ Part 2
NETWORK MANAGEMENT & CREDENT	TALING (NET-CR)	
CR 1: Health Services Contracting (formerly QI 3)			
Element A: Practitioner Contracts (formerly QI 3, Element A)	Attest	✓	✓ Part 1
Element B: Affirmative Statement (formerly QI 3, Element B)	Attest	✓	✓ Part 1
Element C: Provider Contracts (formerly QI 3, Element C)	Attest	✓	✓ Part 1
CR 2: Credentialing Verification (formerly CR 3)			
Element A: Verification of Credentials (file review) (formerly CR 3, Element A)	✓	✓	✓Part 2
Element B: Sanction Information (file review) (formerly CR 3, Element B)	✓	✓	✓ Part 2
Element C: Credentialing Application (file review) (formerly CR 3, Element C)	✓	✓	✓Part 2
CR 3: Recredentialing Cycle Length (formerly CR 4)			

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Element	Renewal	First	Interim
Element A: Recredentialing Cycle Length (file review) (formerly CR 4, Element A)	√ 13	✓	✓ Part 2
CR 4: Ongoing Monitoring and Interventions (formerly CR 5)	<u>.</u>		
Element A: Ongoing Monitoring and Interventions (formerly CR 5, Element A)	√	✓	✓Part 2
CR 5: Notification to Authorities and Practitioner Appeal Rights (formerl	y CR 6)		
Element A: Actions Against Practitioners (formerly CR 6, Element A)	Attest14	✓	✓ Part 1
CR 6: Assessment of Organizational Providers (formerly CR 7)			
Element A: Review and Approval of Provider (formerly CR 7, Element A)	Attest	✓	✓ Part 1
Element B: Medical Providers (formerly CR 7, Element B)	Attest	✓	✓ Part 1
Element C: Behavioral Healthcare Providers (formerly CR 7, Element C)	✓	✓	✓ Part 1
Element D: Assessing Medical Providers (formerly CR 7, Element D)	✓	✓	✓ Part 2
Element E: Assessing Behavioral Healthcare Providers (formerly CR 7, Element E)	√	✓	✓Part 2
NET 1: Availability of Practitioners			
Element A: Cultural Needs and Preferences (formerly NET 1, Element A)	✓	✓	✓ Part 2
Element B: Practitioners Providing Family Care (formerly NET 1, Element B)	Attest	✓	✓Part 2
Element C: Practitioners Providing Specialty Care (formerly NET 1, Element C)	Attest	✓	✓Part 2
Element D: Practitioners Providing Behavioral Healthcare (formerly NET 1, Element D)	Attest	✓	✓Part 2
NET 2: Accessibility of Services	<u></u>		<u>.</u>
Element A: Access to Primary Care (formerly NET 2, Element A)	Attest	✓	✓ Part 2
Element B: Access to Behavioral Healthcare (formerly NET 2, Element B)	Attest	✓	✓ Part 2
Element C: Access to Specialty Care (formerly NET 2, Element C)	Attest	✓	✓ Part 2
NET 3: Assessment of Network Adequacy Note: Plans will be required to submit analyses reports from NET 1–NET 2 to	aid review and so	oring of NET 3.	
Element A: Assessment of Member Experience Accessing the Network (formerly NET 3, Element A)	✓	✓	✓ Part 2
Element B: Opportunities to Improve Access to Nonbehavioral Healthcare Services (formerly NET 3, Element B)	√	✓	✓Part 2
Element C: Opportunities to Improve Access to Behavioral Healthcare Services (formerly NET 3, Element C)	√	✓	✓ Part 2
NET 4: Continuity and Coordination of Medical Care (formerly QI 5)			
Element A: Identifying Opportunities (formerly QI 5, Element A)	Attest	✓	✓ Part 2
Element B: Acting on Opportunities (formerly QI 5, Element B)	Attest	✓	✓ Part 2

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Element	Renewal	First	Interim
Element C: Measuring Effectiveness (formerly QI 5, Element C)	√ 15	✓	✓ Part 2
Element D: Transition to Other Care (formerly QI 5, Element D)	✓	✓	✓ Part 2
NET 5: Continuity and Coordination Between Medical Care and Behavio	ral Healthcare (fo	ormerly QI 6)	•
Element A: Data Collection (formerly QI 6, Element A)	Attest16	✓	✓ Part 2
Element B: Collaborative Activities (formerly QI 6, Element B)	Attest	✓	✓ Part 2
Element C: Measuring Effectiveness (formerly QI 6, Element C)	✓	✓	✓ Part 2
NET 6: Continued Access to Care (formerly NET 5)	1		•
Element A: Notification of Termination (formerly NET 5, Element A)	Attest	✓	✓ Part 2
Element B: Continued Access to Practitioners (formerly NET 5, Element B)	Attest	✓	✓ Part 2
NET 7: Physician and Hospital Directories (formerly NET 6)			•
Element A: Physician Directory Data (formerly NET 6, Element A)	✓	✓	✓ Part 2
Element B: Physician Directory Updates (formerly NET 6, Element B)	Attest	✓	✓ Part 2
Element C: Assessment of Physician Directory Accuracy (formerly NET 6, Element C)	✓	✓	✓ Part 2
Element D: Identifying and Acting on Opportunities (formerly NET 6, Element D)	✓	✓	✓ Part 2
Element E: Searchable Physician Web-Based Directory (formerly NET 6, Element F)	✓	✓	✓ Part 2
Element F: Hospital Directory Data (formerly NET 6, Element G)	✓	✓	✓ Part 2
Element G: Hospital Directory Updates (formerly NET 6, Element H)	Attest	✓	✓ Part 2
Element H: Searchable Hospital Web-Based Directory (formerly NET 6, Element J)	✓	✓	✓ Part 2
Element I: Usability Testing (formerly NET 6, Element K)	Attest	✓	✓ Part 2
Element J: Availability of Directories (formerly NET 6, Element L)	Attest	✓	✓ Part 2
NET 8: Delegation (formerly NET 7)			_
Element A: Delegation Agreement (formerly NET 7, Element A)	✓	✓	✓ Part 2
Element B: Predelegation Evaluation (formerly NET 7, Element B)	✓	✓	✓ Part 2
Element C: Review of Delegate's Credentialing Activities (formerly NET 7, Element C)	✓	✓	✓ Part 2
Element D: Opportunities for Improvement (formerly NET 7, Element D)	✓	✓	✓ Part 2
UTILIZATION MANAGEMENT	Γ(UM)		
UM 1: Communication Services (formerly UM 3)			
Element A: Access to Staff (formerly UM 3, Element A)	Attest	✓	✓ Part 2
UM 2: Appropriate Professionals (formerly UM 4)			
Element A: Licensed Health Professionals (formerly UM 4, Element A)	Attest	✓	✓ Part 2
	- I		

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Element	Renewal	First	Interim
Element B: Use of Practitioners for UM Decisions (formerly UM 4, Element B)	Attest ¹⁷	✓	✓ Part 2
Element C: Practitioner Review of Nonbehavioral Healthcare Denials (file review) (formerly UM 4, Element C)	√ 18	✓	✓ Part 2
Element D: Practitioner Review of Behavioral Healthcare Denials (file review) (formerly UM 4, Element D)	~	✓	✓ Part 2
Element E: Practitioner Review of Pharmacy Denials (file review) (formerly UM 4, Element E)	~	✓	✓ Part 2
Element F: Affirmative Statement About Incentives (formerly UM 4, Element G)	Attest	✓	✓ Part 1
UM 3: Timeliness of UM Decisions (formerly UM 5)			
Element A: Notification of Nonbehavioral Decisions (formerly UM 5, Element B)	~	✓	✓ Part 2
Element B: Notification of Behavioral Healthcare Decisions (file review) (formerly UM 5, Element D)	~	✓	✓ Part 2
Element C: Notification for Pharmacy Decisions (file review) (formerly UM 5, Element F)	~	✓	✓ Part 2
Element D: Interim—Policies and Procedures (formerly UM 5, Element H)	Attest	✓	✓ Part 1
UM 4: Clinical Information (formerly UM 6)			
Element A: Relevant Information for Nonbehavioral Healthcare Decisions (file review) (formerly UM 6, Element A)	√	√	✓ Part 2
Element B: Relevant Information for Behavioral Healthcare Decisions (file review) (formerly UM 6, Element B)	√	√	✓ Part 2
Element C: Relevant Information for Pharmacy Decisions (file review) (formerly UM 6, Element C)	√	√	✓ Part 2
UM 5: Denial Notices (formerly UM 7)			
Element A: Discussion a Denial with a Reviewer (file review) (formerly UM 7, Element A)	~	✓	✓ Part 2
Element B: Written Notification of Nonbehavioral Healthcare Denials (file review) (formerly UM 7, Element B)	√	✓	✓ Part 2
Element C: Nonbehavioral Healthcare Notice of Appeal Rights/ Process (file review) (formerly UM 7, Element C)	√	✓	✓ Part 2
Element D: Discussing a Behavioral Healthcare Denial With a Reviewer (file review) (formerly UM 7, Element D)	√	✓	✓ Part 2
Element E: Written Notification of Behavioral Healthcare Denials (file review) (formerly UM 7, Element E)	✓	✓	✓ Part 2
Element F: Behavioral Healthcare Notice of Appeals Rights/Process (file review) (formerly UM 7, Element F)	✓	✓	✓Part 2
Element G: Discussing a Pharmacy Denial with a Reviewer (file review) (formerly UM 7, Element G)	✓	√	✓ Part 2

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¹⁷ Organizations attest to maintaining required activities but do not submit evidence in the Interactive Review Tool (IRT) for surveys. ~10% of plans will annually be required to submit evidence for elements designated with "attest."

¹⁸ Organizations are required to submit evidence for elements designed with a check-mark.

Element	Renewal	First	Interim
Element H: Written Notification of Pharmacy Denials (formerly UM 7, Element H)	√ 19	✓	✓Part 2
Element I: Pharmacy Notice of Appeals Rights/Process (file review) (formerly UM 7, Element I)	√	✓	✓ Part 2
UM 6: Policies for Appeals (formerly UM 8)			
Element A: Internal Appeals (formerly UM 8, Element A)	Attest ²⁰	✓	✓ Part 1
UM 7: Appropriate Handling of Appeals (formerly UM 9)			
Element A: Preservice and Postservice Appeals (file Review) (formerly UM 9, Element A)	√	✓	✓ Part 2
Element B: Timeliness of Appeal Process (file review) (formerly UM 9, Element B)	√	✓	✓ Part 2
Element C: Appeal Reviewers (file review) (formerly UM 9, Element C)	✓	✓	✓Part 2
Element D: Notification of Appeal Decision/Rights (file review) (formerly UM 9, Element D)	√	✓	✓ Part 2
Element E: Final Internal and External Appeal Files (file review) (formerly UM 9, Element E)	✓	✓	✓ Part 2
Element F: Appeals Overturned by the IRO (file review) (formerly UM 9, Element F)	✓	✓	✓ Part 2
UM 8: Evaluation of New Technology (formerly UM 10)			
Element A: Written Process (formerly UM 10, Element A)	Attest	✓	✓ Part 1
Element B: Description of the Evaluation Process (formerly UM 10, Element B)	Attest	✓	✓ Part 1
UM 9: Procedures for Pharmaceutical Management (formerly UM 11)			
Element A: Pharmaceutical Management Procedures (formerly UM 11, Element A)	√	✓	✓ Part 1
Element B: Pharmaceutical Restrictions/Preferences (formerly UM 11, Element B)	✓	✓	✓ Part 1
Element C: Pharmaceutical Patient Safety Issues (formerly UM 11, Element C)	✓	✓	✓ Part 1
Element D: Reviewing and Updating Procedures (formerly UM 11, Element D)	√	✓	✓ Part 1
Element E: Considering Expectations (formerly UM 11, Element E)	✓	✓	✓ Part 1
UM 10: Delegation of UM (formerly UM 12)			
Element A: Delegation Agreement (formerly UM 12, Element A)	✓	✓	✓ Part 2
Element B: Predelegation Evaluation (formerly UM 12, Element B)	✓	✓	✓ Part 2
Element C: Review of UM Program (formerly UM 12, Element C)	✓	✓	✓ Part 2
Element D: Opportunities for Improvement (formerly UM 12, Element D)	✓	✓	✓ Part 2

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 $^{^{\}rm 19}$ Organizations are required to submit evidence for elements designed with a check-mark.

²⁰ Organizations attest to maintaining required activities but do not submit evidence in the Interactive Review Tool (IRT) for surveys. ~10% of plans will annually be required to submit evidence for elements designated with "attest."

Element	Renewal	First	Interim
MEMBER EXPERIENCE (M	IE)		·
ME 1: Statement of Members' Rights and Responsibilities (formerly RR 1)		
Element A: Rights and Responsibilities Statement (formerly RR 1, Element A)	√ 21	✓	✓ Part 1
ME 2: Subscriber Information (formerly RR 3)			
Element A: Subscriber Information (formerly RR 3, Element A)	✓	✓	✓ Part 1
Element B: Interpreter Services (formerly RR 3, Element B)	Attest ²²	✓	✓ Part 1
ME 3: Marketing Information (formerly RR 4)			•
Element A: Materials and Presentations (formerly RR 4, Element A)	✓	✓	✓ Part 1
Element B: Communicating with Prospective Members (formerly RR 4, Element B)	Attest	✓	✓ Part 1
Element C: Assessing Member Understanding (formerly RR 4, Element C)	Attest	✓	✓ Part 2
ME 4: Functionality of Claims Processing (formerly MEM 1)	<u>.</u>		
Element A: Functionality—Website (formerly MEM 1, Element A)	Attest	✓	✓ Part 2
Element B: Functionality—Telephone Requests (formerly MEM 1, Element B)	Attest	✓	✓ Part 2
ME 5: Pharmacy Benefit Information (formerly MEM 2)	<u>.</u>		
Element A: Pharmacy Benefit Information—Website (formerly MEM 2, Element A)	Attest	✓	✓ Part 2
Element B: Pharmacy Benefit Information—Telephone (formerly MEM 2, Element B)	Attest	✓	✓ Part 2
Element C: QI Process on Accuracy of Information (formerly MEM 2, Element C)	✓	✓	✓ Part 2
Element D: Pharmacy Benefit Updates (formerly MEM 2, Element D)	✓	✓	✓ Part 2
ME 6: Personalized Information on Health Plan Services (formerly MEM 3	3)		
Element A: Functionality—Website (formerly MEM 3, Element A)	✓	✓	✓ Part 2
Element B: Functionality—Telephone (formerly MEM 3, Element B)	✓	✓	✓ Part 2
ME 7: Member Experience (formerly RR 2, QI 4 C-F, MEM 3 C-D)			
Element A: Policies and Procedures for Complaints (formerly RR 2, Element A)	Attest	✓	✓ Part 1
Element B: Policies and Procedures for Appeals (formerly RR 2, Element B)	Attest	✓	✓ Part 1
Element C: Annual Assessment of Nonbehavioral Healthcare Complaints & Appeals (formerly QI 4, Element C)	Attest	✓	✓ Part 2
Element D: Nonbehavioral Opportunities for Improvement (formerly QI 4, Element D)	✓	✓	✓Part 2

Organizations are required to submit evidence for elements designed with a check-mark.
 Organizations attest to maintaining required activities but do not submit evidence in the Interactive Review Tool (IRT) for surveys. ~10% of plans will annually be required to submit evidence for elements designated with "attest."

Element	Renewal	First	Interim
Element E: Annual Assessment of Behavioral Healthcare and Services (formerly QI 4, Element E)	Attest	✓	✓ Part 2
Element F: Behavioral Healthcare Opportunities for Improvement (formerly QI 4, Element F)	√ 23	✓	✓ Part 2
Element G: Quality and Accuracy of Information (formerly MEM 3, Element C)	✓	✓	✓ Part 2
Element H: Email Response Evaluation (formerly MEM 3, Element D)	✓	✓	✓Part 2
ME 8: Delegation (formerly RR 5)			
Element A: Delegation Agreement (formerly RR 5, Element A)	✓	✓	✓Part 2
Element B: Predelegation Evaluation (formerly RR 5, Element B)	✓	✓	✓Part 2
Element C: Review of Performance (formerly RR 5, Element C)	✓	✓	✓Part 2
Element D: Opportunities for Improvement (formerly RR 5, Element D)	✓	✓	✓ Part 2

²³ The organized is required to submit evidence for elements designed with a check-mark.

How to Submit Comments

Submitting Comments

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

- 1. Go to http://my.ncqa.org and enter your email address and password.
- 2. Select the **Public Comments** module to view available public comment.
 - a. Click Open Public Comments to view instructions, proposed requirements and questions.
- 3. Click **Add Comment** to open the comment box.
- 4. Select the following products from the drop-down box:
 - a. Health Plan Accreditation (HPA) 2020
 - b. Long-Term Services and Supports (LTSS).
- Click to select the Topic and Element (question) on which you would like to comment.
- 6. Click to select your support option (Support, Do not support, Support with modifications).
 - a. If you choose **Do not support**, include your rationale in the text box.
 - b. If you choose **Support with modifications**, enter the suggested modification in the text box.
- 7. Enter your comments in the **Comments** box.

Note: There is a 2,500-character limit for each comment. We suggest you develop your comments in Word to check your character limit; use the "cut and paste" function to copy your comment into the Comments box.

8. Use the **Submit** button to submit more than one comment. Use the **Close** button to finish leaving comments; you can view all submitted comments in the **Public Comments** module.

All comments must be entered by Monday, December 17, by 11:59 p.m. ET

Next Steps

The final HPA 2020 standards and guidelines will be released in July 2019, following approval by the NCQA Standards Committee and the Board of Directors.

Requirements for HPA 2020 are applicable for surveys beginning July 1, 2020.