Accreditation: Enhancing the Value of Exchanges

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Task Force on Federal Health Reform Implementation
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Overview

- Section 1311 Qualified Health Plan Certification Requirement for Accreditation
- Nationally Recognized Accreditors of Health Plans
- Readiness to Accredit QHPs
- “Real World” Affect of Accreditation
- Practical Value of Accreditation
- Accreditation Process & Timelines
- Q&A
About URAC

- To promote continuous improvement in the quality and efficiency of healthcare management through processes of accreditation and education.
- Non-profit, independent entity
- Broad-based governance
  - Providers
  - Purchasers
  - Labor
  - MCO's
  - Regulators
  - Consumers
  - Expert Advisory Panels (Volunteer)
- Consumer Protection and Empowerment.
- Improving and Innovating Healthcare Management.

Mission
Structure
Strategic Focus

URAC Accreditation in the Managed Care Sector

URAC: Since 1990

URAC pioneered utilization management accreditation by creating a nationally recognized set of standards to ensure accountability in managed care determinations of medical necessity.

Consumers Affected

URAC accredits programs for over 95 health plans representing over 79 million covered lives.

Government Recognition

URAC programs are recognized by five federal agencies, over 45 states and the District of Columbia.
Section 1311 QHP Certification Requirement: Accreditation

PPACA Section 1311(c)(1)(D)(i) requires that all health plans offered through state insurance exchanges be accredited with respect to local performance on clinical quality measures such as the HEDIS, patient experience ratings on a standardized CAHPS survey, as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans (so long as any such entity has transparent and rigorous methodological and scoring criteria)."

ACCREDITATION:

An evaluative, rigorous, transparent and comprehensive process in which a healthcare organization undergoes an examination of its systems, processes and performance by an impartial external organization ("accrediting body") to ensure that it is conducting business in a manner that meets predetermined criteria and is consistent with national standards. This independent evaluation typically occurs in two stages starting with an examination of documentation during an off-site “desktop review” followed by an “onsite survey” of operations.

Accreditation Bodies for Health Plans

- urac
- NCQA
Nationally Recognized Accreditation Organizations Contribution to Exchanges

- Industry Expertise
- Accreditation Experience
- Widespread Recognition
- Independent, Rigorous, and Publicly Transparent Standards and Measures Development Process
- Comprehensive and Thorough Accreditation Process
  - Desktop Review
  - On-Site Review
  - Ongoing Compliance Monitoring
  - Investigation of Consumer and Regulator Complaints
  - Corrective Action Plans

Readiness to Accredit QHPS

The URAC Health Plan Accreditation Program (V. 7.0, 2011) Aligns with PPACA §1311

- Ensures Transparency
- Promotes Consumer Protections
- Empowers Consumers
- Mental Health Parity Act
- Robust & Transparent Scoring
- Patient Experience Survey
- Measures that Matter
Readiness to Accredit QHPS

- Clinical Quality Measures in the URAC Health Plan Program: Measures That Matter
- Aligns w/ HHS National Quality Priorities
- Will Demonstrate Quantitative Results
- Promotes QI, Efficiency & Effectiveness
- Manageable Administrative Burden
- Nationally-Endorsed Measures in the Public Domain
- Standardization Across Industry

Accreditation Can Provide Flexibility to States

- URAC’s Health Plan Program Accomodates Specific State Requirements
- URAC Health Insurance Exchange Addendum Will Align with HHS Rules

Modular Approach of URAC Programs
Experience Incorporating Local Requirements
URAC Health Insurance Exchange Addendum to URAC Health Plan Program Will Reflect Final HHS Regulations
Key Policy Issues Addressed by Accreditation

**Consumer Protection**
- Network Adequacy
- Market Conduct
- Utilization Management
- Mental Health Parity
- Health Disparities & Literacy
- Consumer Communications & Disclosures (i.e., Patient Information Programs)
- Consumer Access
- Complaints and Appeals
- Network Adequacy and Access

**Quality Assurance**
- Provider Credentialing
- Measures & Survey Reporting
- Quality Management Initiatives
- Network Performance
- Patient Safety
- Care Coordination
- Case Management, Drug Therapy Management & Disease Management

**Accreditation Addresses Key Stakeholder Concerns**

**Plans**
- Quality of care
- Avenues to improve care management
- Maintaining healthy members
- Delivering quality relative to cost
- Quality provider networks
- Patient Centered Care

**Employers**
- Intersection of Quality & Cost
- Employee engagement
- Transparency of cost
- Keeping employees healthy
- Effective management of care
- Care Coordination

**Government**
- Improving quality
- Improving health & clinical outcomes
- Reducing hospital preventable admissions and re-admissions
- Care coordination
- Assuring patient safety
- Effective management of care

**Consumers**
- Receiving quality care
- Being informed & engaged in care decisions
- Staying healthy
- Understanding options and best choices
- Communications
- Provider access

Bolded text: PPACA §1311(c)(1)(D)(i)
“Real-World” Affect of Accreditation

- **Discharged Diabetic Gets Wrong Dosage**
  - URAC Accreditation Standard Addresses Medication Safety
  - Requires Plans to Monitor RX Reconciliation at Care Transitions
  - HP Case Mgr Found Major Dosage Error in Discharge Papers

- **Providers Refuse to See Patients**
  - URAC Reviewer Found 700 Complaints/1 Month No Timely Claims Payment
  - Network Providers Refuse Patients
  - Plan Not Tracking Complaints from Members and Providers

- **Premie Baby Re-Hospitalized**
  - Utilization Management & Medical Necessity Guidelines
  - Plan Changes Formulary & Considers it Coverage Change
  - No Denial Letter → No Appeal for Prescribed Medication

Practical Value of Accreditation for Regulators

- **Independent Third Party Auditor**
- **Cost-Effective Supplement to State Resources**
- **Provides Regulators with Helpful Documentation (e.g., Accreditation Summary Reports)**
- **Accreditation Programs Developed by Stakeholders and Experts across the Health Care Spectrum**
- **Avenue for Consumers and Regulators to File Complaints**
- **Accreditation Programs Regularly Updates to Keep Pace with Current Best Practices and Health Care Advancements**
URAC Accreditation Review Process
(approximately 4-6 months)

- Pre-Application Support
- Application Submitted
- Desktop Review
  Request for Additional Information
- Interactive Educational
  Onsite Review
- Accreditation Committee Review
- Accreditation Cycle Commences
- Mid-cycle Monitoring Onsite
- Measurement Reporting

Types of Accreditation Categories

- **Full Accreditation**: All Mandatory standard elements are met and weighted standard score is $\geq 94$ points/100
- **Conditional Accreditation**: One mandatory standard/element is not met and/or weighted standard score is $\geq 90$, but $< 94$ points/100
- **Corrective Action**: Two mandatory standards/elements are not met and/or weighted standard score is $\geq 85$, but $< 90$ points/100
- **Denial**: Three or more mandatory standards/elements are not met and/or weighted score is $< 85$ points/100
URAC Resources

- As the health care industry evolves, URAC continues to address emerging issues by revising its standards and creating new accreditation programs to keep pace with health care advancements and help to drive improvements in the industry.

- URAC now offers more than 25 accreditation and certification programs in the areas of medical care management, health care operations, pharmacy quality management and health information technology.

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ADDENDUM: More on the “Real-World” Affect

Discharged Diabetic Gets Wrong Dosage
URAC Accreditation Standard Address Medication Safety requires that Plans monitor medication reconciliation at transitions of care. Case Manager (CM) in accredited plan caught dosage error in 73 yo diabetic’s discharge orders, which called for 100 units of insulin. CM called hospital, which cited chart at 100 units. CM called physician, who said 100 units was not correct order and adverse patient medication event was avoided.

Providers Refuse to See Patients
Accreditation Reviewer found 700 complaints/1 month from providers/consumers when reviewing files for Plan in individual market. Found network providers refusing to see patients because on non-timely payment of claims, due to Plan software glitch. Plan was not appropriately tracking complaints from members and providers.

Premie Baby Re-Hospitalized
Importance of Utilization Management Guidelines illustrated when Plan changed formulary and considered it coverage change rather than medical necessity issue, and refused to give Baby’s Mom denial letter so that she could appeal and request prescribed medication.