



States Implement Health Reform



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Accreditation to Approve Health Plans and Providers

Overview

The 2010 federal Affordable Care Act (ACA) calls for use of accreditation to ensure quality in the managed health care sector and provide resources to state policymakers through public-private partnerships.¹

“Accreditation” is a comprehensive evaluation process in which a health care organization’s systems, processes and performance are examined 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.

More than 45 states currently use accreditation of a variety of health care organizations as part of their overall strategy to evaluate—and at times improve—the quality and cost-effectiveness of care and to promote compliance with state laws.

Key Federal Provisions

Accreditation will play a role under the new health reform legislation, as states and the federal government continue to supplement managed care oversight activities with data from private accreditation reviews. The following sections of the ACA specifically mention accreditation.

Section 1311: Affordable Choice of Health Benefit Plans

- The ACA requires that, beginning in 2014, all health plans offered through state insurance exchanges “...must be accredited with respect to local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set (HEDIS), patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems (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).”
- The secretary of Health and Human Services (HHS) is expected to recognize accrediting bodies before January 2012, since health plans will need to be accredited before they can be included in, and offered on, health insurance exchanges in 2014.

Section 2719: External Review Appeals Process

- The ACA requires all health plans to provide external review processes that include the consumer protections set forth in the National Association of Insurance Commissioners (NAIC) Uniform Health Carrier External Review

Model Act (Model Act), through compliance with the federal external review process or applicable state external review processes. A federal rule (*Federal Register*, July 23, 2010) establishes the federal external appeals process and requires independent review organizations (IROs) to be accredited. Provisions of the Model Act apply to state insurance commissioners, health carriers, independent review organizations and covered people.

- The NAIC Model Act establishes a streamlined method for approving IROs and recognizes IROs as eligible to conduct external reviews if they are accredited by a nationally recognized private accrediting entity, approved by the state insurance commissioner as meeting the standards in the federal ACA and the NAIC state model act.

Additional provisions in the ACA address activities and programs that are the subject of accreditation programs, such as medical homes, case management and disease management, wellness programs, medication therapy management services, pharmacy benefit management, utilization review and quality of care improvement.

Legislative and State Roles

Accreditation bodies or entities evaluate and rate a wide variety of health care organizations, including care management companies, health insurance plans, pharmacy benefit managers, utilization review organizations, wellness organizations, and other health vendors, both in the commercial sphere and through government programs such as Medicare and Medicaid.

Within the ACA, accreditation serves as a recognized component to states and state legislators as they implement



health reform and address health care issues. Many state laws already include accreditation standards for health care management, health care operations, health information technology and pharmacy quality management activities as a quality assurance tool.

Accreditation includes a process that identifies best practices and promotes continuous quality improvement supported by ongoing performance measurement. Advisory groups help to draft and periodically review accreditation standards. The independent evaluation itself typically occurs in two stages, starting with an examination of documentation during an off-site “desktop review” followed by an “on-site survey” of operations.

Health care organizations that earn accreditation from a nationally recognized accrediting entity validate their level of achieving quality and accountability. Through the accreditation process, accrediting entities can encourage health care organizations to keep pace with emerging evidence-based clinical and quality improvement standards more readily than if undertaken by legislation or regulation alone.

Existing Accrediting Organizations

More than 30 organizations accredit health care companies in the United States, encompassing all sectors of the health care industry. Some organizations accredit customers across multiple industry segments (e.g., The Joint Commission), while others may serve a single customer type (e.g., the Commission on Office Laboratory Accreditation). U.S. accrediting entities for health care providers dominate the landscape (75 percent), followed by accrediting entities for managed care (16 percent), and health care technology (9 percent). Eight of the top 10 U.S. health accreditors service health care providers (e.g., hospitals, health facilities, imaging and laboratories), while two accredit managed care companies (e.g., URAC/American Accreditation Healthcare Commission and the National Committee for Quality Assurance). Government regulators evaluate accreditors based on the government’s programmatic goals and the applicability of accreditation standards. The Centers for Medicare and Medicaid Services (CMS), for example, conducts a rigorous assessment of accreditors before granting them “deemed” status to determine, on CMS’ behalf, compliance with specific CMS requirements.

Government Recognition of Accreditation

In the commercial insurance market, many states use accreditation to comply with state licensure or contract requirements. Some states also require accreditation before an organization can perform a certain function, such as utilization management or external medical necessity reviews. Accreditation often supplements state regulations and reduces

the burdens of state oversight by enabling regulators to focus limited agency resources on problematic areas identified in audits.

The federal government, state governments and the District of Columbia currently reference accreditation programs in their statutes, regulations, agency publications and contracts. The Federal Employees Health Benefits Program, for example, recognizes accreditation and includes the specific accreditations awarded to health plans in the benefit information available to federal employees. The Centers for Medicare and Medicaid Services uses several accrediting bodies in the Medicare Advantage Deeming Program. CMS also allows individual states to use private accreditation reviews to assess compliance with Medicaid managed care regulations.

Additional Resources

Accreditation Statutes or Regulations URAC State Recognitions Searchable Directory: <http://webapps.urac.org/grdirectory/directorysearch.asp>

Map and Summaries of State Recognitions, NCQA: <http://www.ncqa.org/tabid/135/Default.aspx>

Map and Summaries of State Recognitions, URAC: http://www.urac.org/policyMakers/resources/Map-Chart_20101206.pdf; <http://www.urac.org/policyMakers/resources/governmentRecognition.aspx>

NAIC Model Act on exchanges, that references accreditation: http://www.naic.org/index_health_reform_section.htm

NAIC Healthcare Reform Implementation: http://www.naic.org/index_health_reform_section.htm

NAIC Uniform Health Carrier External Review Model Act: http://www.naic.org/documents/committees_b_uniform_health_carrier_ext_rev_model_act.pdf

NCSL Accreditation and State Insurance Regulation, 2011; <http://www.ncsl.org/default.aspx?tabid=22452>

NGA: <http://www.nga.org/>

Accreditation Organization Resources

Center for Consumer Information and Insurance Oversight (CCIO): <http://www.hhs.gov/ccio/>

HHS/CMS Guidance: <http://www.healthcare.gov/> and <http://www.hhs.gov/>

URAC: www.urac.org

Joint Commission (TJC): www.jointcommission.org/

NCQA: www.ncqa.org/

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Note

1. Section 1311(C)1 Affordable Choices of Health Benefit Plans and Section 1001, as amended by §10101, of the Patient Protection and Affordable Care Act (PPACA), Pub. L. 111–148 adds Section 2719 to the Public Health Service Act.



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