ATTACHMENT A

Summary of Compliance Determination Activities of Public and Private Quality Oversight Organizations

American Accreditation Health Care Commission/URAC - National Network Accreditation Program

The Commission/URAC is a private, non-profit accrediting organization that accredits managed care organizations (MCOs). Commission/URAC accreditation products assess either all or selected (e.g. utilization or case management) components of a MCO. The Commission/URAC Accreditation attests to the extent to which an agency complies with structural and operational standards established by the Commission/URAC. The process begins with a review of documents submitted by the application organization, designed to make an initial determination of whether or not the applicant meets each of the standards. Additional information may be requested from the organization as a part of this process. Topics addressed in the review include network participation and management, quality management, utilization management, provider credentialing, and member participation and protection.

This "paper review" is followed by an onsite review that is carried out according to an agenda agreed upon between the Commission/URAC and the managed care organization to be reviewed. Interviews are conducted with key staff of the MCO/PIHP responsible for implementing the MCO's/PIHP's managed care functions, including the medical director, quality assurance manager, provider contracting manager, credentialing manager, and others as indicated. Additional documents are also reviewed. This may include credentialing files, minutes, appeal process documentation, etc.

Based on the findings, the Accreditation Committee makes a recommendation to the Commission/URAC Executive Committee regarding accreditation. Accreditation is conferred for a two-year period.

Health Care Financing Administration - Medicare Contractor Performance Monitoring System

Reviews of MCOs that contract with Medicare are conducted every two years using the *Contractor Performance Monitoring System* inspection instrument specified by HCFA. In addition, during the two-year period, sections of the review instrument may be used to conduct focus reviews or enforcement reviews when issues are identified. Sections of the instrument may also be used to determine if corrective action plans, resulting from prior reviews, have been implemented. Issues that may trigger intra-cycle reviews include provider or beneficiary complaints, such as nonpayment of claims.

The length of the review depends on the membership size and overall scope of the MCO. Typically, a standard review using the entire survey instrument takes two to four reviewers three to four days to complete. Depending on the need to conduct an in-depth investigation, an enforcement review may take additional days.

A pre-site visit letter and suggested agenda for the review is made available to the MCO prior to the on-site visit. Revisions in this agenda may be made by the reviewers onsite, depending upon their findings.

In some instances there may be a desk review of documents supplied by the MCO conducted before the onsite review.

Providers may be interviewed during the review of the MCO. These interviews are usually conducted by telephone. The principal focus of the review of delegated services is to assess the MCO's oversight process.

At the conclusion of a survey, the reviewers share preliminary findings with the MCO. A final report is prepared and returned to the MCO shortly after the onsite review. It includes the deficiencies identified and requires submission of a corrective action plan by the organization.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) - Accreditation Program for Health Care Networks

The Joint Commission network accreditation process includes an assessment of the central operations of an MCO/PIHP and visits to settings (components) where members of the MCO/PIHP actually receive care (e.g., hospitals, ambulatory surgery centers, long term care facilities, home care agencies, and physician offices).

The network central offices are surveyed against the standards in the *Comprehensive Accreditation Manual for Health Care Networks.* Issues addressed include rights, responsibilities, and ethics; continuum of care; education and communication; health promotion and disease prevention; leadership; management of human resources; management of information; and improving network performance.

Surveys are three to five days in duration. They are conducted by surveyors with extensive experience in managed care settings. They include physicians, nurses, administrators, and other health care professionals.

Pre survey information is limited to the application, a pre survey planning questionnaire, and information on the structure of the network. Lists of care settings (components and practitioner offices) are submitted. From these, using a sampling methodology, sites to be visited as part of the survey are selected.

The components are surveyed by individuals with both managed care and setting-specific survey and professional experience. The standards are drawn from the network manual, as well as a subset of the field-specific accreditation manuals. These visits are intended to ascertain the extent to which the care setting is carrying out its responsibilities to provide care and service to the members of the network. As well, a determination is made regarding the effectiveness of the network in supporting the care setting in its role.

Surveyors use a defined agenda for all onsite activity. It is negotiated with the network prior to the survey by staff in the Central Office.

Surveyors use computer technology to record their findings. They supply the network with a preliminary report at the conclusion of the survey. This includes a tentative accreditation decision.

There is post-survey review of the report, under rules determined by the Accreditation Committee of the Board of Commissioners. Appeals of adverse decision are also possible to the Board Accreditation Review Committee.

Networks are accredited for three years.

National Committee for Quality Assurance (NCQA) - Accreditation Program for Managed Care Organizations

The accreditation survey of a MCO by NCQA begins with the submission of an application to NCQA for accreditation review. The application contains detailed information about the MCO. This information is intended to determine the accreditable entity of the MCO, its product lines and products. The MCO can select which product lines (e.g., HMO, PPO) it wishes to have accredited. Assuming that these activities meet the eligibility requirements, NCQA establishes a survey process to address the selected activities. There is a desktop review of information submitted by the MCO, which occurs six weeks before the onsite survey. This desktop review includes such things as program descriptions, policies and procedures, and member materials. Other documentation review takes place as a part of the onsite survey process.

Onsite surveys are from two to four days in duration. At a minimum, a survey team consists of two members -- a physician and an administrator. A full scope survey will usually have a team of four members -- two physicians and two administrators. Surveyors typically have experience in, and responsibility for, quality management in their own organizations. Surveyors carry out their activities through review of documents and records, onsite observation, and interviews with staff.

On-site review includes file review - UM denials, credentialing and recredentialing files, complaint and appeals files, and medical records. Surveyors are data collectors and evaluators. They assign the preliminary compliance designations. File review results are reviewed with the MCO's staff. One of five levels of compliance can be assigned to each standard. Topics

addressed in the review include quality management, utilization management, credentialing, members' rights and responsibilities, medical records, and preventive health services programs.

During the summation conference, the survey team identifies key strengths and opportunities. Surveyors will not come to conclusions regarding standards compliance or the overall possible accreditation status of the organization at the summation conference. The team submits its findings to a Review Oversight Committee (ROC) composed of 14 physicians, who all have managed care experience, who make the accreditation decision. This can be appealed to a Reconsideration Committee by the MCO. The decision of the Reconsideration Committee is final.

In addition to conducting an onsite survey to determine the MCO's compliance with the standards (worth 75 points), since 1999, NCQA also determines how well the MCO performs on selected audited measures from the Health Plan Employer Data and Information Set (HEDIS), and Consumer Assessment of Health Plans Study (CAHPS). The total score allocated to HEDIS and CAHPS is 25 points - 12.5 points for each. This data is required of accredited organizations on an annual basis. Performance on these measures will influence the accreditation decision annually if changes occur. An MCO's accreditation status is thus re-evaluated annually. A standards score is valid up to three years.

END OF ATTACHMENT A