NCQA Accreditation Roadmap

Achieve NCQA Health Plan Accreditation

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1. Understanding NCQA Accreditation

The National Committee for Quality Assurance (NCQA) is a private, non-profit organization that accredits health plans based on quality standards covering clinical care, member service, and administrative processes. NCQA accreditation is widely recognized by employers, regulators, and consumers as a mark of quality.

Why Pursue NCQA Accreditation?

- Demonstrates commitment to quality improvement and accountability
- Required by many state Medicaid contracts and employer groups
- CMS recognizes NCQA accreditation for Medicare Advantage "deemed" status
- Competitive advantage in the marketplace
- Framework for systematic quality improvement
- Reduces regulatory burden through deemed status provisions

Accreditation Levels

- Excellent: Highest level - meets or exceeds all standards
- Commendable: Above average performance across standards
- Accredited: Meets NCQA standards
- Provisional: Does not fully meet standards but shows commitment
- Denied: Does not meet NCQA requirements

Types of NCQA Accreditation

- Health Plan Accreditation (HPA) - comprehensive plan evaluation
- Managed Behavioral Healthcare Organization (MBHO)
- Credentials Verification Organization (CVO)
- Wellness and Health Promotion
- Utilization Management / Precertification

2. Accreditation Standards Overview

NCQA Health Plan Accreditation evaluates organizations across several standard categories. Each category contains multiple elements with specific requirements that must be demonstrated.

Standard Categories

- Quality Management and Improvement (QI)
- Utilization Management (UM)
- Credentialing and Recredentialing (CR)
- Members' Rights and Responsibilities (RR)
- Member Connections (includes HEDIS and CAHPS)
- Population Health Management (PHM)
- Network Management (NET)

Scoring Methodology

Each element is scored on a scale:

- 100% (Full Credit): Fully meets all requirements
- 75% (Significant Credit): Substantially meets requirements
- 50% (Partial Credit): Partially meets requirements
- 25% (Minimal Credit): Minimally addresses requirements
- 0% (No Credit): Does not meet requirements

> *Important: NCQA uses a "look-back" period for evaluation. Most standards require evidence of compliance over the prior 12-24 months, not just point-in-time compliance.*

3. The Accreditation Process

Phase 1: Application and Preparation

- Submit application and fee to NCQA
- Receive access to NCQA interactive survey system
- Complete organizational self-assessment
- Gather documentation for all applicable standards
- Timeline: 6-12 months before target survey date

Phase 2: Document Submission

- Upload required documentation to NCQA portal
- Submit HEDIS data and CAHPS survey results
- Provide policies, procedures, and program descriptions
- Include sample files (credentialing, UM, grievances)
- Submit organizational charts and committee structures

Phase 3: On-Site Survey

- NCQA surveyors conduct 2-3 day on-site review
- Staff interviews across all standard areas
- File reviews (credentialing, UM cases, complaints)
- System demonstrations (claims, authorization, member services)
- Leadership interviews (CEO, CMO, QI Director)

Phase 4: Scoring and Decision

- NCQA review committee evaluates survey findings
- Accreditation decision issued within 60-90 days
- Organizations may request reconsideration if denied
- Accreditation valid for 3 years (annual reporting required)

4. Quality Management and Improvement

QI Program Requirements

- Written QI program description updated annually
- QI committee with physician leadership and defined roles
- Annual QI work plan with measurable objectives
- Annual QI program evaluation assessing effectiveness
- Board-level reporting on QI activities and outcomes

Clinical Quality Measures

- HEDIS measure collection, reporting, and improvement activities
- Clinical practice guideline adoption and dissemination
- Preventive health programs and screening initiatives
- Chronic condition management programs
- Patient safety and adverse event monitoring

Key Requirements

- Demonstrate measurable improvement in clinical indicators
- Use data to identify priorities and allocate resources
- Engage providers in quality improvement initiatives
- Member engagement in quality programs
- Continuous improvement methodology (PDSA, Lean, Six Sigma)

5. Utilization Management Standards

UM Program Structure

- Written UM program description reviewed annually
- Licensed physician oversight of all UM decisions
- Evidence-based clinical criteria for decision-making
- Inter-rater reliability testing program
- Annual UM program evaluation

Decision-Making Requirements

- Standard pre-service decisions within 15 calendar days
- Urgent/concurrent decisions within 24-72 hours based on type
- Post-service decisions within 30 calendar days
- Peer-to-peer review opportunity before adverse decisions
- Written notification with denial reason and appeal rights

Appeal and Denial Management

- First-level appeals reviewed by physician not involved in initial denial
- Second-level appeals with external review option
- Continuation of services during appeal when clinically appropriate
- Tracking and trending of denial and appeal data
- Under/over-utilization monitoring and intervention

6. Credentialing and Recredentialing

Initial Credentialing

- Written credentialing policies and procedures
- Credentialing committee with physician participation
- Complete application with required attestations
- Primary source verification of all required elements
- Decision within 180 calendar days of complete application

Required Verifications

- Current, valid license to practice (primary source)
- DEA or CDS certificate (if applicable)
- Education and training verification
- Board certification status
- Hospital privileges (if applicable)
- Malpractice insurance coverage
- NPDB query
- State sanctions and exclusion list checks
- Work history (5-year review)

Recredentialing

- Recredentialing every 3 years (36-month cycle)
- Updated primary source verifications
- Review of practitioner performance data
- Member complaint and quality data review
- Ongoing monitoring between credentialing cycles

Organizational Providers

- Facility credentialing per NCQA standards
- CMS certification, state licensure verification
- Accreditation status review
- Malpractice/liability coverage confirmation

- On-site quality assessment (if applicable)

7. Members' Rights and Responsibilities

Required Member Protections

- Written member rights and responsibilities statement
- Non-discrimination policies and procedures
- Privacy and confidentiality protections (HIPAA compliance)
- Access to medical records and personal health information
- Informed consent processes
- Right to voice complaints and appeals without retaliation

Member Communication

- Clear, readable member materials at appropriate literacy level
- Multi-language materials and interpreter services
- Provider directory accuracy and updates
- New member orientation and onboarding
- Annual member satisfaction surveys (CAHPS)

Complaint and Appeal System

- Accessible complaint filing process (multiple channels)
- Timely acknowledgment and resolution
- Written resolution with rationale
- External review/appeal options clearly communicated
- Complaint data used for quality improvement

8. Member Connections (HEDIS and CAHPS)

HEDIS Requirements

The Healthcare Effectiveness Data and Information Set (HEDIS) is the primary measurement tool used by NCQA to evaluate health plan performance. Plans must report annually on approximately 90+ measures across domains.

- Effectiveness of care (preventive, chronic condition management)
- Access and availability of care
- Experience of care
- Utilization and relative resource use
- Health plan descriptive information

CAHPS Survey

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey measures member experience and satisfaction. Results factor heavily into accreditation scoring.

- Getting needed care and timeliness
- How well doctors communicate
- Customer service quality
- Rating of health plan and personal doctor
- Claims processing and coordination of care

Performance Improvement

- Identify lowest-performing HEDIS measures for targeted improvement
- Develop provider incentive programs tied to quality measures
- Implement member outreach for preventive care gaps
- Track and report improvement trends year-over-year

9. Preparing for Your NCQA Survey

Preparation Timeline (18 months)

- Month 18-12: Gap analysis and program assessment

- Month 12-9: Policy updates and process improvements

- Month 9-6: Documentation compilation and file preparation

- Month 6-3: Mock survey and remediation

- Month 3-1: Staff interview preparation and logistics

- Final month: Document submission and site preparation

Critical Success Factors

- Executive sponsorship and organizational commitment

- Dedicated project manager for accreditation preparation

- Cross-functional team with clear accountability

- Evidence of sustained compliance (not just point-in-time)

- Strong HEDIS and CAHPS performance

- Comprehensive file documentation across all standard areas

Common Preparation Pitfalls

- Starting too late (less than 12 months before survey)

- Focusing on policies without demonstrating implementation

- Insufficient HEDIS/CAHPS improvement efforts

- Inadequate staff preparation for interviews

- Missing or incomplete credentialing files

- Lack of measurable QI outcomes

10. Maintaining Accreditation Status

Annual Reporting Requirements

- Submit annual HEDIS data to NCQA

- Complete CAHPS survey annually

- Report material changes to organizational structure

- Maintain compliance with all standards between surveys

- Address any mid-cycle compliance concerns promptly

Continuous Readiness

- Maintain "accreditation-ready" documentation year-round

- Track NCQA standards updates and implement changes

- Monitor HEDIS trends and implement improvement strategies

- Conduct annual internal assessments against NCQA standards

- Prepare for triennial resurvey starting 18 months in advance

Ready to pursue or maintain NCQA accreditation? Contact Ginete Healthcare Consulting Group: Email: hello@ginete.co | Phone: (818) 308-5476 | Web: ginete.co