Accreditation of Managed Care Organizations

by Susan L. Probyn, RRA

It is common knowledge in the healthcare industry that every few years most hospitals undergo rigorous review to become accredited. Less well known is the fact that many managed care organizations are following suit and undergoing an accreditation process of their own. Several organizations have emerged during the last several decades to facilitate managed care accreditation, including the National Committee for Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC), and the Joint Commission on Accred-itation of Healthcare Organizations (the Joint Commission). Each has developed standards and maintains thorough accreditation processes.

National Committee for Quality Assurance

NCQA was founded in 1979 to make health plans accountable for the quality of care and services they deliver through accreditation and the development of measures to gauge health plan performance.

Health plans can apply for NCQA accreditation if they provide comprehensive services through a defined delivery system to a specific population and have been operating for 18 months. The average plan takes approximately nine months to prepare for a survey. NCQA accreditation is not based on a minimum set of standards. Instead, the accreditation review is a comprehensive process to validate that the managed care organization is founded on the principles of quality and is continuously improving clinical care and services. Through the review experience, performance measures are developed, allowing for comparison between health plans in "report cards." Many employers have acknowledged the value of accreditation by requiring NCQA accreditation of the health plans they offer their employees. In addition, several states, including Florida, Kansas, Oklahoma, Pennsylvania, and Vermont, require external quality reviews of managed care organizations to obtain licensure.

The NCQA accreditation survey includes both on-site and off-site review and is conducted by a team of physicians, nurses, and administrators. The preassessment phase is conducted prior to the site visit and involves an extensive review of documentation sent to NCQA by the plan. The on-site survey lasts between two and four days, depending on the size of the plan, and includes additional document review, interviews with key staff members, and medical record review. The post-survey phase involves the preparation of preliminary findings, which are reviewed by the Review Oversight Committee, prior to the preparation of the final report.

NCQA's standards fall into the following categories:

- Quality improvement
- Utilization management
- Physician credentialing
- Member rights and responsibilities
- Preventive health services
- Medical records/peer review

Accreditation includes full, one-year, provisional, and denial determinations. Full accreditation lasts for three years and distinguishes those plans with highly effective quality improvement programs. Approximately one-third of health plans are granted full accreditation. One-year accreditation (including a list of recommendations for further development) is granted to plans with well-established quality programs. The plan is reviewed after one year to determine if it can progress to full accreditation. Provisional accreditation means that the plan has adequate quality programs but needs to demonstrate progress before it qualifies for a higher level of accreditation.

The *Accreditation Status List*, a listing of the current status of health plans that have undergone or are undergoing accreditation, is released every month. Anyone who wishes to obtain a copy of the list can do so by contacting NCQA.

Accreditation Summary Reports have recently been developed and are scheduled to be released in 1996 on plans undergoing full review after July 1995. The reports will reflect the health plan's performance in each standard category and compare it to the average performance in each category.

The performance measurement arm of NCQA is the Health Plan Employer Data and Information Set (HEDIS). HEDIS 2.0, released in 1993, consists of 60 standardized measures of health plan performance in the areas of quality, access and patient satisfaction, membership and utilization, finance and health plan management. The current version, HEDIS 2.5, is a comprehensive update of the specifications in HEDIS 2.0. HEDIS 3.0 is currently under development.

Utilization Review Accreditation Commission

URAC was established in 1990 to encourage efficient and effective utilization review processes and to provide a method of evaluation and accreditation for utilization review programs. At that time, there was concern in the industry that there was too much diversity in the way that utilization review (UR) procedures were applied. Through the development and promulgation of minimum industry standards, which serve as a basis for a voluntary credentialing process, URAC's goal is to continually improve the quality and efficiency of the interaction between the utilization review industry and the providers, payers, and purchasers of healthcare.

The *National Utilization Review Standards*, published in January 1990, were designed to

- Encourage consistency in utilization review procedures
- Establish processes that cause minimal disruption to the healthcare delivery system
- Establish standards for the procedures used to certify medical services and to process appeals of certification determination
- Provide the basis for an efficient process of credentialing and accrediting UR organizations
- Provide consistent standards and an accreditation mechanism that can be applied efficiently nationwide for those states that choose to regulate UR organizations

The standards apply to all organizations offering UR services that seek national accreditation through URAC and apply to prospective, concurrent, and retrospective utilization review for inpatient admissions and outpatient procedures and services.

Standards fall into the following categories:

- Confidentiality
- Responsibility for obtaining certification
- Staff and program qualifications
- Accessibility and on-site review procedures
- Information on which UR is conducted
- Procedures for review determination
- Appeals process

Most accreditation reviews are done without an on-site survey. Applications are submitted to URAC, where staff conduct a thorough "desktop" review of materials and interview key staff via the telephone. If additional information is needed, the organization is given 30 days to submit appropriate materials.

Once this phase is completed, the blinded application is reviewed by the Accreditation Committee, which recommends to the Executive Committee that the facility either be granted or denied accreditation. Other recommendations can include placing the applicant in a 90-day correction period or requiring an on-site review. The Executive Comm-ittee makes the final determination. Accreditation is for a two-year period. If questioned regarding the status of an organization, URAC responds with either "Yes," and the date accredited, "No," if not accredited, "In process," or if the company has not applied.

URAC recently expanded its scope beyond UR and has developed *National Network Accreditation Standards*. These standards will apply to all organizations offering managed care networks that seek national accreditation.

Joint Commission on Accreditation of Healthcare Organizations

The Joint Commission entered the managed care arena with the 1994 publication of *Accreditation Standards for Healthcare Networks*. The program is designed to accredit entities that provide integrated healthcare to a defined population of individuals. It further defines "network" as an entity that offers comprehensive or specialty services and is characterized by a centralized structure that coordinates and integrates services provided by component organizations and practitioners.

Networks seeking Joint Commission accreditation must meet the follow-ing criteria:

- The network has a process for assessing the quality of its services that involves reviews of care by clinicians
- The network is located in the US or is operated by the US government
- When applying, the network identifies all services that it provides directly, under contract, or through some other arrangement

The survey process, survey team, and length of survey are determined by the composition of the network. Compli-ance with the standards is assessed through verbal information, on-site observations by Joint Commission surveyors, and review of documents that demonstrate compliance. The Joint Commission is investigating the feasibility of developing accreditation tracks for this program in the future.

The network standards fall into the following categories:

- Rights, responsibilities, and ethics
- Continuum of care
- Education and communication
- Leadership
- Management of human resources
- Management of information
- Improving network performance

Accreditation decisions include accreditation with commendation, accreditation with or without recommendations,

provisional accreditation, conditional accreditation, and nonaccreditation. The Accreditation Committee is responsible for all accreditation determinations. The Joint Commission maintains a list of organizations and their accreditation status and will release, upon request and for a $30 fee per organization, the information to the public.

The Joint Commission also has a performance measurement system, the Indicator Measurement System (IMSystem). They recently distributed a Request for Indicators, soliciting indicators applicable to the managed care setting.

Eventually the IMSystem will be incorporated into the accreditation processes of all Joint Commission accreditation programs.

The increasing demand for quality healthcare at reasonable cost will require the continued expansion and evolution of all healthcare accreditation bodies, especially those in the managed care industry. In the not-too-distant future, managed care organizations will be catching up to other healthcare entities in percentages of organizations accredited. This growth continues to open the door to many new career opportunities for professionals familiar with the overall accreditation process. Health information management professionals would be wise to prepare for and enter this exciting alternative setting.

References

Joint Commission on Accreditation of Healthcare Organizations. *Accreditation Manual for Healthcare Net-works*. Oakbrook Terrace, IL: Joint Commission on Accredi-tation of Healthcare Organi-zations, 1994.

National Committee for Quality Assurance. *Reviewer Guidelines for the Standards for Accreditation of Managed Care Organizations*. Washington, DC: National Committee for Quality Assurance, 1995.

Utilization Review Accreditation Commission. *National Utilization Review Standards*. Washington, DC: Utilization Review Accreditation Commission, 1994.

Resources

For more information or to obtain copies of standards, contact the organizations below.

National Committee for Quality Assurance (NCQA)
2000 L Street, NW, Suite 500
Washington, DC 20036
(202) 955-3500

Utilization Review Accreditation Commission (URAC)
1130 Connecticut Ave, NW, Suite 450
Washington, DC 20036
(202) 296-0120

Joint Commission on Accreditation of Healthcare Organizations
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
(708) 916-5600

Article citation:
Probyn, Susan L.. "Accreditation of Managed Care Organizations" *Journal of AHIMA* 67, no.1 (January 1996): 30-32.