State of Hawaii
Department of Human Services
Med-QUEST Division

DEEMED STATUS

A RECOMMENDED STRATEGY FOR THE MED-QUEST DIVISION

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HSAG HEALTH SERVICES ADVISORY GROUP

1600 East Northern Avenue, Suite 100 ◆ Phoenix, AZ 85020
Phone 602.264.6382 ◆ Fax 602.241.0757

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Introduction

Health Services Advisory Group, Inc. (HSAG) is contracted with the State of Hawaii, Department of Human Services (DHS), Med-QUEST Division (MQD) to provide external quality review (EQR) services for the State's Medicaid managed care program. As part of these EQR services, the MQD has requested that HSAG develop a strategy and recommendations for implementing "deemed status" for its QUEST and QUEST Expanded Access (QExA) managed care health plans.

The purpose of this document is to provide information and technical assistance to the State of Hawaii, Med-QUEST Division, regarding the applicability of the federal managed care regulations for nonduplication of external quality review of its managed care health plans. This document provides an overview of the deemed status regulations and the associated requirements, a set of guiding principles for decision-making, and recommendations for including deemed status in the State's quality strategy and managed care contracts. Appendices to this document contain cross-walks of select federal and State requirements to the applicable national accrediting body standards.

Information sources for development of this document include:

- The Electronic Code of Federal Regulations accessed at http://ecfr.gpoaccess.gov/
- The Federal Register, Vol. 68, No. 16, dated January, 24, 2003 (also referred to herein as "the preamble")
- The Centers for Medicare & Medicaid Services (CMS) Web site accessed at www.cms.hhs.gov
- The National Commission on Quality Assurance (NCQA) Web site accessed at www.ncqa.org
- The American Accreditation Healthcare Commission/URAC (URAC) Web site accessed at www.urac.org

In addition, the RFPs and contracts between the State of Hawaii DHS/MQD and its contracted health plans are referenced as applicable - for the QUEST plans, the RFP issued June 14, 2006; for the QExA plans, the RFP issued October 10, 2007.

Nonduplication of Mandatory Activities

Overview

The federal managed care regulations, at 42 CFR 438.360, provide an optional mechanism for states to use to prevent duplication of the mandatory compliance monitoring activities for its managed care plans, when a plan has had a similar review performed by either Medicare or an approved national accrediting organization. Managed care organizations, therefore, can be considered to have "deemed" compliance. Standards reviewed by the accrediting organization must be duplicative of the state's standards for access, structure and operations, and measurement and improvement. Two areas that may not be considered to be deemed compliant on the basis of this alternative review are conducting performance improvement projects and the calculation of performance measures, except if the managed care plan serves only dual eligibles (recipients eligible under both Medicare and Medicaid).

Requirements for Accrediting Organizations (AOs)

The Balanced Budget Act of 1997 (BBA) gave CMS the authority to establish and oversee a program that allows private, national accreditation organizations to "deem" that a Medicare Advantage managed care organization is compliant with certain Medicare requirements. Six areas are deemable: quality assurance, antidiscrimination, access to services, confidentiality and accuracy of enrollee records, information on advance directives, and provider participation rules. The Medicaid managed care regulations for external quality review at 42 CFR 438.360 provide the same option for deeming Medicaid MCOs, and specify the deemable areas to include the Medicaid managed care regulations of Subpart D for access to care, structure and operations, and measurement and improvement.

To be approved for deeming authority, an AO must demonstrate to CMS that its program meets or exceeds the requirements for which it is seeking the authority to deem compliance. The AO may seek deeming authority for any or all of the categories that may be deemed. CMS follows a rigorous application process with stringent criteria and an onsite review with observation of the AO's survey process. CMS also employs an equivalency review, which includes a review of a crosswalk that the AO prepares to demonstrate its comparability to the CMS requirements, processes, and enforcement activities.

National Committee for Quality Assurance (NCQA), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and Accreditation Association for Ambulatory Health Care were approved accrediting organizations with deeming authority for Medicaid MCOs/PIHPs as of January 24, 2003. On May 26, 2006, CMS also approved URAC as an accrediting organization whose standards meet or exceed the federal managed care regulations, and therefore can be deemed compliant. Both NCQA and URAC have published their cross-walks on their respective Web sites, and these resources were used in the preparation of Appendices to this report.

Requirements for Granting Deemed Status to a Managed Care Organization

The nonduplication regulation provides states the option to use information from a Medicare or private accreditation review to avoid duplication with the review of select standards required under 42 CFR 438.204(g) (also known as compliance monitoring, a mandatory EQR activity). The standards that may

be considered for this deemed compliance as referenced at 438.204(g) are those listed in Subpart D of the regulations for access to care, structure and operations, and measurement and improvement.

One exception is that activities required under 42 CFR 438.240(b)1&2 (for conducting performance improvement projects [PIPs] and for calculating performance measures) are an option for deeming only for plans that serve only dual eligibles. Related discussion in the preamble, page 3603, supports the Department of Health and Human Services (DHHS)/Centers for Medicare & Medicaid Services (CMS) decision to continue to require validation activities for PIPs and performance measures regardless of whether compliance is otherwise being deemed. As the MQD does not currently contract with managed care plans whose membership consists of only dually eligible recipients, this exception does not apply.

Certain requirements must be met for a state to exercise the option to prevent duplication through deeming of its contracted health plans:

1. The managed care organization (MCO) or prepaid inpatient health plan (PIHP) must be in compliance with Medicare or national accreditation organization standards and those standards must be comparable to the state's standards to comply with 438.204(g) and the EQR related activity under 438.358 (b)(3).
2. The MCO/PIHP must have achieved "fully accredited" status from the AO in the areas to be deemed. Fully accredited means that the standards within the deeming category have been surveyed by the AO and determined to be fully met or otherwise acceptable without significant findings, recommendations, or corrective actions.
3. MCO/PIHP compliance with standards must have been determined by CMS/its Medicare contractor or a private accrediting organization approved by CMS under 422.158. The preamble states this accreditation is not required to have been performed on an MCO's/PIHP's Medicaid product/population. The MCO/PIHP must provide all results applicable to standards in 438.204(g) of the Medicare or private accreditation organization's review to the state; the state must in turn provide the results to the EQR organization.
4. The state must identify in its quality strategy the standards for which it will use information from a Medicare or private accreditation organization review and the rationale for why it is duplicative.

Hawaii Revised Statute §432E-11 requires that managed care plans doing business in Hawaii become accredited by a national accrediting organization. Currently, the QUEST health plans are accredited by either NCQA or URAC. The QExA plans have not been operating in Hawaii for sufficient time to seek accreditation yet.

Guiding Principles and Decision-Making for the Deemed Status Option

Consistent with the MQD's mission statement and its quality strategy objectives, implementing a mechanism for deeming compliance of its contracted managed care plans provides opportunities for the State to achieve accountability, transparency, and efficiency. Toward that goal, the MQD is interested in developing a model and guiding principles for use of the deeming option that is both equitable to the managed care plans and supportive of the State's monitoring and oversight responsibilities. An incremental approach has been selected by the MQD, adding deemable standards or areas over time and building upon the managed care plans' performance review results and successful attainment of accreditation status.

Proposed Guiding Principles

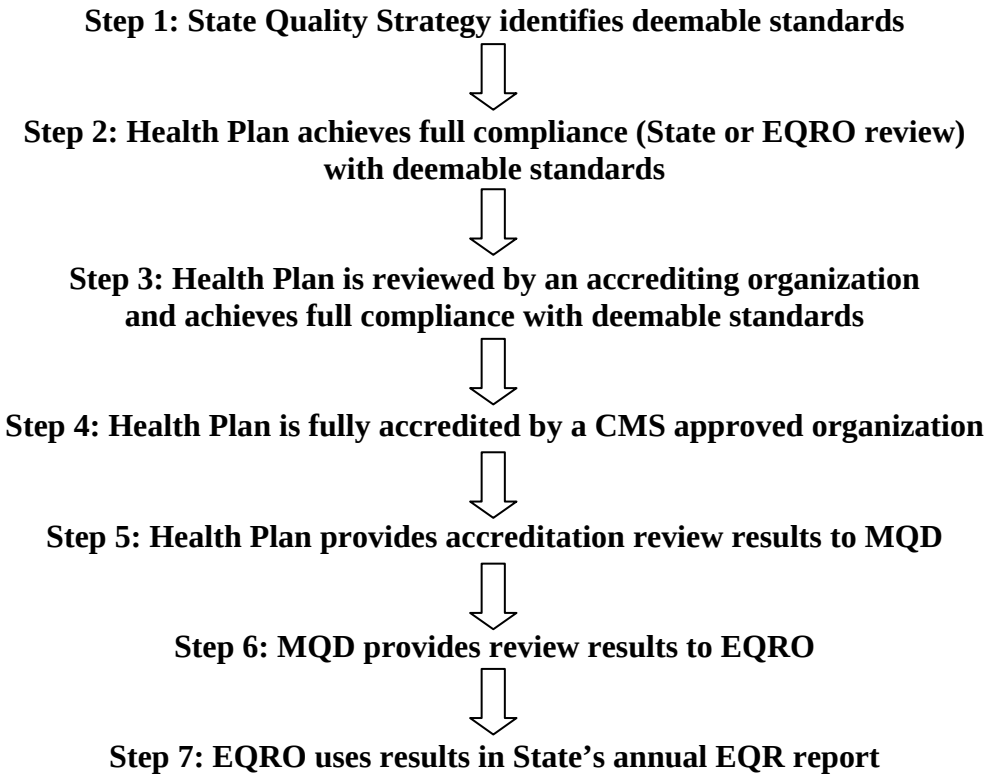
To implement its deeming mechanism for Hawaii's Medicaid managed care program, the MQD will adhere to the following guiding principles. The purpose of these principles is to provide a framework for decision-making as the deeming option is implemented.

- The MQD strives to provide active oversight and monitoring of its contracted managed care plans. It also takes its responsibility for efficient and effective use of resources seriously and, therefore, is committed to ensuring nonduplication of oversight efforts where and when prudent to do so.
- The MQD recognizes its primary responsibility is to ensure that Medicaid recipients have access to and receive coordinated, comprehensive, and high quality care provided by its contracted health plans.
- The MQD is committed to ensuring that the State's quality strategy includes a specific plan for exercising the deemed compliance option for its managed care entities, and to updating the strategy as necessary to communicate to CMS and to interested stakeholders the State's implementation of this option.
- The MQD expects that all information related to performance reviews of its contracted managed care plans is made available by the plan to the MQD for use in implementing this deeming option, whether the review organization has been paid by the MQD or the health plan.
- The MQD has the authority and responsibility to make all decisions as to whether, and to what extent, a contracted managed care plan may be deemed compliant for purposes of exercising this option.

Proposed Decision Model

As described previously, certain requirements must be met in order for a state to implement a deeming mechanism, and for a managed care plan to be eligible for deemed compliance. Following is a high-level flow diagram of the decision-making process for a plan's eligibility for deemed compliance. An expanded discussion of the considerations related to each step in the decision process is also included below.

Flow Diagram of the Decision-Making Process



Step 1: State Quality Strategy identifies deemable standards
The State must identify in its quality strategy the standards for which it will use information from a Medicare or private accreditation organization review and the rationale for why it is duplicative of the State's or EQRO's review. Only those standards included in the quality strategy as submitted to CMS are eligible for consideration of deemed compliance. The MQD utilizes cross-walks to demonstrate equivalency and duplication of standards which will be deemable.

Step 2: Health Plan achieves compliance (State or EQRO review) with deemable standards
To be considered for deemed compliance, the QUEST or QExA plan must have had at least one full review of compliance for the deemable standards by the State or its EQRO within the previous three year period. All standards must have been found fully compliant or must have been brought into full compliance through implementation of a corrective action plan (CAP) within the three year period.

Step 3: Health Plan is reviewed by an accrediting organization and achieves full compliance with deemable standards
To be considered for deemed compliance, the QUEST or QExA plan must have achieved a favorable rating from the accrediting organization within the previous three year period, and all standards must

have been found fully compliant or must have been brought into full compliance through implementation of a CAP within the three year period.

Step 4: Health Plan is fully accredited by a CMS approved organization
To be considered for deemed compliance, the QUEST or QExA plan must be fully accredited (or certified, in the case of Medicare) within the previous three year period, and must be in good standing with the accrediting or certifying body. CMS currently recognizes the following organizations as approved for purposes of this deeming option: NCQA, JCAHO, AHC, URAC, Medicare.

Step 5: Health Plan provides accreditation review results to MQD
To be considered for deemed compliance, the QUEST or QExA plan must furnish to the MQD all documentation of accrediting body review results that pertain to the areas or standards that are being considered for deemed compliance. Results must include reports of findings, recommendations, required corrective actions, implementation of corrective actions, sanctions from the organization, as well as a copy of the health plan's accreditation certificate with effective dates and status.

Step 6: MQD provides review results to EQRO
The MQD will timely provide a copy of the above documentation to the State's EQRO, for inclusion in its evaluation of the health plan. The findings will be used as supplemental information for the EQRO's compliance review of the health plan, in order to prevent duplication of the deemable standards.

Step 7: EQRO uses results in State's annual EQR report
The EQRO will also use the report of findings in its external quality review of the health plan's provision of timely, accessible, and quality services to its Medicaid members. This report, as defined at 42CFR438.364 is an annual requirement and is produced by the EQRO for the State as a deliverable to CMS.

Additional Recommendations and Considerations for the MQD

- If a review by Medicare or an accreditation body on a health plan's Medicare or commercial line of business is to be considered and accepted for deeming compliance for the QUEST or QExA plan's Medicaid program, the following aspects of that program should be comparable to the plan's Medicaid program:
  - Geographic service area and availability/coverage of services
  - Network composition
  - Management and health plan operations policies/procedures
  - Quality management structure and process
  - Enrollee information
  - Practice guidelines

- Consider planning for reevaluation of the deeming strategy and crosswalks periodically, taking into account accreditation status time frames, changes in BBA/state regulations and contract requirements, changes in accrediting organizations' standards, new directions or priorities in the State's quality strategy, etc. As these standards and requirements are dynamic, exercising the deeming option will require some level of ongoing review and update to the crosswalks.

- Consider planning for additional deemable standard areas to be phased in following the next full State or EQRO compliance review. Decisions for additional areas to be eligible for future deeming could then be based on the results of the reviews, selecting those areas where the plans demonstrated high compliance, for example. The State's quality strategy would then need to be updated to include the decisions to phase in additional deemable areas.

Appendix A. Crosswalk of Deemable Regulations to NCQA Standards

The Crosswalk of Deemable Regulations to NCQA Standards follows this cover page.

Crosswalk of Deemable Regulations to NCQA Standards for

Credentialing and Recredentialing of Providers

Medicaid Managed Care Regulation	HI State Medicaid Requirement QUEST Plans	 QExA Plans	NCQA Standard for MCOs (2009)	Equivalency	Explanation and Remedy for Any Almost, Partially, or Not Met Items
42 CFR 438.214 (b) (1)Each State must establish a uniform credentialing and recredentialing policy that each MCO, PIHP, and PAHP must follow.	QUEST RFP issued June 14, 2006	QExA RFP issued October 10, 2007			
(2) Each MCO, PIHP, and PAHP must follow a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with the MCO, PIHP, or PAHP.	40.210 The health plan shall maintain written policies and procedures for the credentialing and recredentialing of network providers, using standards established by the NCQA.	40.400 The health plan shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.	CR1: Credentialing Policies (A,B) CR2: Credentialing Committee (A,B) CR3: Initial Credentialing Verification (A,B) CR4: Application and Attestation (A) CR5: Initial Sanction Information (A) CR6: Practitioner Office Site Quality (A,B) CR7: Recredentialing Verification (A-D) CR8: Recredentialing Cycle Length (A) CR9: Ongoing Monitoring (A) CR10: Notification to Authorities and Practitioner Appeal Rights (A-C) CR11: Assessment of Organizational Providers CR12: Delegation of CR	MET	

Crosswalk of Deemable Regulations to NCQA Standards for

Practice Guidelines

Medicaid Managed Care Regulation	HI State Medicaid Requirement QUEST Plans	 QExA Plans	NCQA Standard for MCOs (2009)	Equivalency	Explanation and Remedy for Any Almost, Partially, or Not Met Items
42 CFR 438.236 (a) The State must ensure, through its contracts, that each MCO meets the requirements of this section.	QUEST RFP issued June 14, 2006	QExA RFP issued October 10, 2007			
(b) Each MCO adopts practice guidelines that meet the following requirements: (1) Are based on valid and reliable clinical evidence or a consensus of health care practitioners in that particular field (2) Consider the needs of the MCO's enrollees (3) Are adopted in consultation with contracting health care professionals (4) Are reviewed and updated periodically as appropriate	50.550 The health plan shall include, as part of its QAPI program, practice guidelines that meet the following requirements. Each adopted practice guideline shall be: • Relevant to the health plan's membership • Based on valid and reliable clinical evidence or a consensus of healthcare professionals in a particular field • Adopted in consultation with in-network providers • Reviewed and updated periodically as appropriate	50.570 (In addition,) the health plan may adopt any other practice guidelines that are: • Relevant to the health plan's membership • Based on valid and reliable clinical evidence or a consensus of healthcare professionals in a particular field • Adopted in consultation with in-network providers All practice guidelines, both those required by DHS and those selected by the health plan, shall be: • Reviewed and updated periodically as appropriate	QI9: Clinical Practice Guidelines The organization is accountable for adopting and disseminating clinical practice guidelines relevant to its members for the provision of nonpreventive acute and chronic medical services and for preventive and nonpreventive behavioral health services. Element A: The organization ensures that practitioners are using relevant clinical practice guidelines by: Adopting guidelines for at least two medical conditions and at least two behavioral health conditions Establishing the clinical basis for the guidelines Updating the guidelines at least every two years	MET	

c) Each MCO disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees	• Disseminated to all affected providers, and upon request, to members and potential members	• Disseminated to all affected providers, and upon request, to members and potential members	Distributing the guidelines to the appropriate practitioners	PARTIALLY MET*	The health plan must undergo a review of its mechanisms for dissemination of practice guidelines, upon request, to members and potential members.
	• Consistent with 42 CFR 438.6(h) and 422.208 regarding physician incentive programs.	• Consistent with 42 CFR 438.6(h) and 422.208 regarding physician incentive programs.		NOT MET	The health plan must undergo a review of its mechanisms to ensure that practice guidelines are consistent with 42 CFR 438.6(h) and 422.208 regarding physician incentive programs.
	The health plan shall submit with its proposal, policies and procedures addressing the stated requirements, a list of all current practice guidelines as well as the practice guidelines adopted specifically for asthma, diabetes, and pregnancy/high risk pregnancy.	The health plan shall include, as part of its QAPI program, practice guidelines related to diabetes mellitus, obesity management, behavioral health, renal disease (prior to end-stage), and cardiovascular disease.	NONE	NOT MET	The health plan must undergo a review of its practice guidelines to ensure that it has adopted guidelines that are required by the State.
(d) Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.	Additionally, in compliance with 42 CFR 438.236, the health plan shall ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.	Additionally, in compliance with 42 CFR 438.236, the health plan shall ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.	UM2: To make utilization decisions, the organization uses written criteria based on sound clinical evidence and specifies procedures for appropriately applying the criteria. Element C: At least annually, the organization: -Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making -Acts on opportunities to improve consistency, if applicable.	PARTIALLY MET*	The health plan must undergo a review of its mechanisms to ensure that decisions for member education and coverage of services are consistent with the guidelines.

*These equivalency designations are assigned by HSAG and are different than those published in NCQA's Standards Crosswalk.

Appendix B. Crosswalk of Deemable Regulations to URAC Standards

The Crosswalk of Deemable Regulations to URAC Standards follows this cover page.

Crosswalk of Deemable Regulations to URAC Standards for

Credentialing and Recredentialing of Providers

Medicaid Managed Care Regulation	HI State Medicaid Requirement QUEST Plans	 QExA Plans	URAC Standard for Health Plans (2009)	Equivalency	Explanation and Remedy for Any Almost, Partially, or Not Met Items
42 CFR 438.214 (b) (1)Each State must establish a uniform credentialing and recredentialing policy that each MCO, PIHP, and PAHP must follow.	QUEST RFP issued June 14, 2006	QExA RFP issued October 10, 2007			
(2) Each MCO, PIHP, and PAHP must follow a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with the MCO, PIHP, or PAHP.	40.210 The health plan shall maintain written policies and procedures for the credentialing and recredentialing of network providers, using standards established by the NCQA.	40.400 The health plan shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.	P-CR 4 – Credentialing Program Plan	NOT MET*	The health plan must undergo a review of its credentialing and recredentialing policies and practices using the NCQA standards, the uniform policy that the state Medicaid agency has chosen.

*These equivalency designations are assigned by HSAG and are different than those published in URAC's Standards Crosswalk.

Crosswalk of Deemable Regulations to URAC Standards for

Practice Guidelines

Medicaid Managed Care Regulation	HI State Medicaid Requirement QUEST Plans	QExA Plans	URAC Standard for Health Plans (2009)	Equivalency	Explanation and Remedy for Any Almost, Partially, or Not Met Items
42 CFR 438.236 (a) The State must ensure, through its contracts, that each MCO meets the requirements of this section.	QUEST RFP issued June 14, 2006	QExA RFP issued October 10, 2007			
(b) Each MCO adopts practice guidelines that meet the following requirements: (1) Are based on valid and reliable clinical evidence or a consensus of health care practitioners in that particular field (2) Consider the needs of the MCO's enrollees (3) Are adopted in consultation with contracting health care professionals (4) Are reviewed and updated periodically as appropriate	50.550 The health plan shall include, as part of its QAPI program, practice guidelines that meet the following requirements. Each adopted practice guideline shall be: • Relevant to the health plan's membership • Based on valid and reliable clinical evidence or a consensus of healthcare professionals in a particular field • Adopted in consultation with in-network providers • Reviewed and updated periodically as appropriate	50.570 (In addition,) the health plan may adopt any other practice guidelines that are: • Relevant to the health plan's membership • Based on valid and reliable clinical evidence or a consensus of healthcare professionals in a particular field • Adopted in consultation with in-network providers All practice guidelines, both those required by DHS and those selected by the health plan, shall be: • Reviewed and updated periodically as appropriate	HUM-1 – Review Criteria Requirements The organization utilizes explicit clinical review criteria or scripts that are: (a) developed with involvement from appropriate providers with current knowledge relevant to the criteria or scripts under review, (b) based on current clinical principles and processes, (c) evaluated at lease annually and updated if necessary by: (i) the organization itself, and (ii) appropriate, actively practicing physicians and other providers with current knowledge relevant to the criteria or scripts under review, and; (d) approved by the medical director (or equivalent designate) or clinical director (or equivalent designate.	NOT MET*	The URAC standard addresses UM review criteria, not clinical practice guidelines. The health plan must undergo a review of its processes for practice guidelines according to the requirements of the BBA and the State's contract.

c) Each MCO disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.	• Disseminated to all affected providers, and upon request, to members and potential members	• Disseminated to all affected providers, and upon request, to members and potential members	HUM-23 – Clinical Rationale for Noncertification Requirements Upon request from the patient, attending physician, or other ordering provider or facility rendering service, the organization provides specific clinical review criteria upon which the non-certification was based.	NOT MET*	The URAC standard addresses UM review criteria, not clinical practice guidelines. The health plan must undergo a review of its mechanisms for dissemination of practice guidelines to affected providers and, upon request, to members and potential members.
	• Consistent with 42 CFR 438.6(h) and 422.208 regarding physician incentive programs.	• Consistent with 42 CFR 438.6(h) and 422.208 regarding physician incentive programs	NONE	NOT MET	The health plan must undergo a review of its mechanisms to ensure that practice guidelines are consistent with 42 CFR 438.6(h) and 422.208 regarding physician incentive programs.
	The health plan shall submit with its proposal, policies and procedures addressing the stated requirements, a list of all current practice guidelines as well as the practice guidelines adopted specifically for asthma, diabetes, and pregnancy/high risk pregnancy.	The health plan shall include, as part of its QAPI program, practice guidelines related to diabetes mellitus, obesity management, behavioral health, renal disease (prior to end-stage), and cardiovascular disease.	NONE	NOT MET	The health plan must undergo a review of its practice guidelines to ensure that it has adopted guidelines that are required by the State.
(d) Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.	Additionally, in compliance with 42 CFR 438.236, the health plan shall ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.	Additionally, in compliance with 42 CFR 438.236, the health plan shall ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.	NONE	NOT MET	The health plan must undergo a review of its mechanisms to ensure that decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

*These equivalency designations are assigned by HSAG and are different than those published in URAC's Standards Crosswalk.