

**State HMO Accreditation and
External Quality Review Requirements:
Implications for HMOs Serving Rural Areas**

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EXECUTIVE SUMMARY

This paper is the second in a series of papers examining the relationship between accreditation and HMOs serving rural areas. The purpose of this paper is (1) to analyze state regulations regarding HMO accreditation and external quality review; (2) to discuss the implications of these regulations for HMOs serving rural areas; and (3) to briefly describe states' experiences in implementing these regulations. The primary focus is on state regulations that require an HMO to seek accreditation or undergo external quality review as a condition of licensure. A secondary focus is on state regulations or contract provisions that require an HMO to be accredited in order to serve state employees.

The incorporation of HMO accreditation and external quality review requirements into state HMO licensure processes and state employee contracting raises several policy issues that are especially relevant to HMOs serving rural populations. A key issue is whether the linkage of accreditation and external quality review requirements to HMO licensure will be an additional deterrent to the development of new HMOs or the expansion of existing HMOs into rural areas. Other issues relate to the costs and benefits of accreditation for HMOs serving rural populations and the potential impact of HMO accreditation requirements on efforts to expand managed care enrollment of rural Medicaid and Medicare beneficiaries and rural state employees.

Analysis of state regulations and interviews with state officials identified nine states that have regulations requiring HMOs to apply for or obtain accreditation, or to undergo an external quality review, as a condition of licensure: Florida, Kansas, Nevada, New Jersey, Oklahoma, Pennsylvania, Rhode Island, South Carolina, and West Virginia. Four states were identified as implementing requirements that an HMO be accredited in order to serve state employees: Alabama, Iowa, Ohio, and Tennessee.

Many state HMO accreditation and external quality review requirements are still in the early stages of implementation, so there has been limited opportunity to assess their impact. As states gain more experience implementing these requirements, it will be especially important to evaluate their rural impact. Several states that have incorporated state HMO accreditation or external quality review requirements into their HMO licensure processes have significant rural populations. The states with state employee HMO accreditation requirements also have substantial rural populations. These states will provide opportunities to evaluate the impact of accreditation and external review requirements on HMOs serving rural areas, rural providers, and rural consumers.

INTRODUCTION

Several states now require HMOs to undergo external quality reviews or accreditation surveys as a condition of gaining HMO licensure or serving state employees. This paper is the second in a series of three papers that explore the relationship between accreditation and the extent to which an HMO serves rural populations. The purpose of this paper is (1) to analyze state regulations regarding HMO accreditation and external quality review; (2) to discuss the implications of these regulations for HMOs serving rural areas; and (3) to briefly describe states' experiences in implementing these regulations. The primary focus is on state regulations that require an HMO to seek accreditation or undergo external quality review as a condition of licensure. A secondary focus is on state regulations or contract provisions that require an HMO to be accredited in order to serve state employees.

The incorporation of HMO accreditation and external quality review requirements into state HMO licensure processes and state employee contracting raises many policy issues. Some of these issues are relevant to all HMOs, including HMOs that serve rural populations. For example, what are the appropriate roles of state HMO regulatory agencies and private accreditation organizations in assessing and ensuring the quality of care provided to HMO enrollees? To what extent are state HMO regulatory and accreditation processes duplicative, and how should they be coordinated?

Other policy issues are especially relevant to HMOs serving rural populations. A key issue is whether the linkage of accreditation and external quality review requirements to HMO licensure will be an additional deterrent to the development of new HMOs or the expansion of existing HMOs into rural areas. State HMO accreditation requirements have the potential to affect how many and which types of HMOs enter rural markets. They may promote the

expansion of large, nationally affiliated, urban-based HMOs, while creating an additional barrier to the development of regionally based HMOs that serve rural areas.

The imposition of HMO accreditation requirements may raise equity issues if a state does not impose similar requirements on other types of health plans such as preferred provider organizations (PPOs). Equity considerations may be especially important in many rural health care markets where HMO penetration is limited, and the predominant form of competition for an HMO may be indemnity insurers and PPOs rather than other HMOs.

State HMO accreditation requirements raise policy issues related to the costs and benefits of accreditation for HMOs serving rural populations and for rural enrollees. For example, how many HMOs serving rural enrollees that would not otherwise choose to apply for accreditation are doing so as a result of these requirements, and at what cost? On the benefit side, how has the incorporation of HMO accreditation and external quality requirements in licensure processes improved the quality of care provided to rural enrollees?

Additional policy issues relate to the potential impact of HMO accreditation requirements on efforts to expand managed care enrollment of Medicaid and Medicare beneficiaries, including rural beneficiaries. Several states allow managed care organizations (MCOs) that are not traditional HMOs, such as Medicaid plans composed of community-based providers, to participate in Medicaid managed care programs. Provider-sponsored organizations (PSOs) represent a similar attempt by the federal government to expand Medicare managed care options. These nontraditional plans may find it especially difficult to commit the resources needed to attain accreditation. Requiring them to obtain accreditation may conflict with efforts to expand managed care enrollment of Medicaid and Medicare beneficiaries.

Requirements that HMOs be accredited to serve state employees also potentially may be in conflict with state policies to expand managed care options for public employees, including those who reside in rural areas. Depending on the number of accredited HMOs that are serving rural areas, this type of requirement may eliminate a managed care option for some state employees living in rural areas.

STUDY DESIGN AND METHODS

Several national accrediting organizations, including the Accreditation Association for Ambulatory Health Care (AAAHC), American Accreditation Healthcare Commission/Utilization Review Accreditation Commission (URAC), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the National Committee for Quality Assurance (NCQA) accredit and conduct external quality reviews of HMOs and other managed care organizations. These four organizations and their accreditation and external review processes are described briefly in Appendix A. In addition, peer review organizations (PROs) in some states conduct external quality reviews of HMOs.

Using information from NCQA, URAC, and AAAHC, eleven states (Connecticut, Florida, Kansas, Nevada, New Jersey, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Vermont, and West Virginia) were initially identified as having some type of state external quality review or accreditation requirements for HMOs (NCQA, 1998; S. Lamb, NCQA, personal communication, February 19, 1998; URAC, 1998; AAAHC, 1998). Five states (Alabama, Iowa, New York, Ohio, and Tennessee) were also initially identified as having some type of accreditation requirement for HMOs desiring to serve state employees (S. Lamb, NCQA, personal communication, February 19, 1998).

These sixteen states were contacted for copies of relevant laws and/or regulations relating to HMO accreditation or external quality review. The laws and regulations were reviewed, followed by phone interviews with state officials during August and September 1998 to clarify provisions of the laws and regulations and to ask about states' implementation experiences.

STATE REGULATIONS REQUIRING HMO ACCREDITATION OR EXTERNAL QUALITY REVIEWS AS A CONDITION OF LICENSURE

HMO Accreditation and External Review Requirements

Our analysis of state regulations and interviews with state officials identified nine states that have regulations requiring HMOs to apply for or obtain accreditation, or to undergo an external quality review, as a condition of licensure (Table 1). Seven of these states require the accreditation survey or external quality review to be conducted using the accrediting organization's standards or a combination of the accrediting organization's and state standards. The Florida and Rhode Island regulations specifically require HMOs operating in those states to obtain accreditation. The New Jersey, Oklahoma, Pennsylvania, South Carolina, and West Virginia regulations require HMOs to apply for accreditation or undergo an external quality review, but do not specifically require the HMO to obtain accreditation. Two states, Kansas and Nevada, require HMOs to obtain an external quality review using state standards. In addition to the nine states that mandate accreditation or external review for all HMOs, Alabama and New Mexico allow state regulators to require an HMO to obtain an external quality review at the discretion of the regulatory agency, for example, when the agency determines that an HMO has a significant quality problem. The Alabama regulations require an HMO to have an external quality assessment performed by an approved expert "when the Department [of Public Health] may direct for cause" (Code of Ala. 420-5-6.13). In New Mexico, an HMO must have

Table 1

State HMO Accreditation and External Review Requirements

State	Requirement	Effective Date	Approved/Accrediting/ Review Organizations
Florida	As a condition of doing business in the state, each HMO and prepaid health clinic shall apply for accreditation within 1 year and be accredited within 2 years of the organization's receipt of its certificate of authority. All HMOs and PHCs must undergo reaccreditation not less than once every 3 years. Accreditation and reaccreditation must be by an organization approved by the Agency for Health Care Administration. A representative of the agency shall accompany the accreditation or review organization throughout the accreditation or assessment process, and a copy of the written report of the accreditation organization must be submitted to the department within 30 days of receipt. The agency will monitor the accreditation status of all HMOs and PHCs, and initiate actions for HMOs that have not applied or not been surveyed within the appropriate time frame, or failed the accreditation survey. (641.512 Florida Statute, 59A-1200.71-1200.72, F.A.C.)	1992	AAAHC, JCAHO, NCQA
Kansas	At least once every 3 years and at such other times as the commissioner may require, an HMO shall obtain an on-site quality of care assessment by an independent quality review organization acceptable to the commissioner. The Insurance Department has approved 7 quality assurance guidelines for use in this review. Upon completion of the review, the reviewing organization prepares a letter to the Insurance Department reporting whether the HMO is compliant, non-compliant, or in qualified compliance with each guideline. (K.S.A. 40-3211)	1987	AAAHC, JCAHO, NCQA, Kansas Foundation of Health Care (local peer review organization)
Nevada	The state board of health shall make an examination concerning the quality of health care services of any HMO and providers with whom such organization has contracts, agreements, or other arrangements pursuant to its health care plan as often as it deems necessary, but not less frequently than once every 3 years. The state delegates review process to NCQA and JCAHO. Reviews are conducted using state quality standards. (NRS 695C.310)	1991	State delegates review process to NCQA and JCAHO

Table 1 (continued)

State	Requirement	Effective Date	Approved/Accrediting/ Review Organizations
New Jersey	Each HMO shall submit, as part of the comprehensive assessment review process, evidence of the most recent external quality audit that has been conducted within 3 years of the date of the comprehensive assessment review. Such audit shall be performed by an external quality review organization (EQRO) approved by the Department. The report shall describe in detail the HMO’s conformance to performance standards established by the EQRO, other national standard-setting bodies for HMOs, and/or state HMO rules. The report shall also describe in detail any corrective actions proposed and/or undertaken and approved by the EQRO. The report shall be submitted to the Department within 60 days of its receipt in final form by the HMO. The HMO shall not be required to receive “accreditation” or “certification” or other such status granted by the EQRO. The Commissioner may grant an HMO a deferral of the external equality audit requirement for a 12-month period if it is in the initial 3 years of start-up operations, and it demonstrates a financial or operational hardship. (N.J.A.C. 8:38-7.2)	1991	AAHC/URAC, JCAHO, NCQA, Peer Review Organization of New Jersey
Oklahoma	The Department of Health shall examine the quality of an HMO’s health care services at least once every 3 years. The Department may conduct the examination or require the HMO to contract for it, selecting an approved independent quality examiner from a list maintained by the Department. The HMO and the quality examiner are to provide the Department access to observe record reviews, interviews, and the on-site summation. The HMO must provide the Department with a copy of the final report within 5 working days. (O.A.C. 310:655-17-11)	Department has required HMOs contract for quality review since 1988-89.	AAAHC, AAHC/URAC, JCAHO, NCQA, HealthPro
Pennsylvania	Within 1 year of receipt of its certificate of authority and 3 years thereafter, or when the Department may direct for cause, each HMO shall have an external quality assurance assessment performed. The assessment shall be conducted by an expert experienced in HMO review activities. The expert shall be approved by the Department. A copy of the expert’s report shall be submitted to the Department within 10 business days of its receipt by the HMO. (28 PA. Code 9.93)	Requirement dates back to 1983, activity began in early 1990s.	AAAHC, NCQA
Rhode Island	The HMO’s quality management program shall be accredited by an organization acceptable to the Department within two years of initial licensure. (R27-4.4.1)	1994	NCQA (JCAHO has applied)

Table 1 (continued)

State	Requirement	Effective Date	Approved/Accrediting/ Review Organizations
South Carolina	Each HMO must have a quality assurance review performed within 3 years of the issuance of a certificate of authority from the Department of Insurance and at least once every 3 years thereafter. The view must be performed by a qualified organization performing audits based upon criteria similar to those set forth in the NCQA guidelines. All review reports must be submitted to the Department upon completion. (S.C. Code Ann. 34-33-170(d))	1987	NCQA
West Virginia	As a condition of doing business in this state, each HMO which has been in existence for at least three years shall apply for and submit to an accreditation examination to be performed by a nationally recognized accreditation and review organization approved by the commissioner. A copy of the written report of the accreditation organization must be submitted to the commissioner within 30 days of receipt. (W. Va. Code 33-25A-17a)	May 1998	AAHC/URAC, NCQA

AAAHC is the Accreditation Association of Ambulatory Health Care, Skokie, IL

AAHC/URAC is the American Accreditation Healthcare Commission/Utilization Review Accreditation Commission, Washington, DC

JCAHO is the Joint Commission for the Accreditation of Healthcare Organizations, Chicago, IL

NCQA is the National Committee for Quality Assurance, Washington, DC

an external quality audit conducted by an approved independent quality review organization “upon request by the Superintendent [of Insurance]” (13 NMAC 10.20.8).

Time Frame for Meeting Accreditation and External Review Requirements

In Kansas, Nevada, Oklahoma, South Carolina, and West Virginia, HMOs have three years from the date of initial licensure to meet the state’s accreditation or external quality review requirement. New Jersey links the time frame for its external quality review requirement to the state’s schedule for comprehensive HMO assessments. This schedule is based on each HMO’s date of licensure, with oldest HMOs being assessed first; any HMOs with certificates of authority issued after July 1997 will be reviewed in three years. Rhode Island allows HMOs two years from the date of initial licensure. Florida requires HMOs to apply for accreditation within one year and be accredited within two years. Pennsylvania requires an external review within one year, which the Pennsylvania Department of Health interprets to mean one year from the time the HMO has enrollees, since some HMOs have their certificates of authority for several months before enrolling members.

Approved Accrediting and External Quality Review Organizations

All nine states require that the external quality review or accrediting organization be approved by the state HMO regulatory agency, usually the Insurance Department or Health Department. Several state regulations do not include the specific criteria to be used in approving the external quality review or accrediting organizations. Florida, Pennsylvania, and West Virginia require the organizations to be “experienced in the appraisal of medical practice and quality assurance in an HMO setting/” The Florida regulations also specify that the organizations must have “at least three years of experience in reviewing all of the types of HMOs commonly found doing business in the State of Florida” and “experience in conducting

accreditation reviews for HMOs in at least five states of the United States or two regions of the Health Care Financing Administration.” Oklahoma has five criteria, including that the quality examiner have written criteria and standards for assessing the quality of clinical care and the availability, accessibility, and continuity of care, and limits clinical judgments to physicians with experience in the delivery of health care in an HMO setting.

NCQA is an approved organization in all nine states with HMO accreditation or external quality review requirements. JCAHO is an approved organization in five states. AAAHC is approved in four states, and URAC in three states. Two states, Kansas and New Jersey, have approved state-level PROs as external quality review organizations.

In states that have approved more than one accreditation or external review organization, state officials indicate that various factors, such as the HMO’s previous experience with one of the accrediting or review organizations, costs, and Medicaid review requirements, appear to influence HMOs’ choices of organizations. Some state officials indicate that a number of HMOs in their states were accredited by NCQA prior to state implementation of an external review or accreditation requirement. In some states, such as Oklahoma, the older, nationally affiliated HMOs are NCQA accredited, while newer HMOs have chosen one of the other accrediting organizations. The lower cost of a PRO review, compared with other options, has influenced several HMOs in Kansas to choose the PRO. The PRO of New Jersey has a contract with the state Medicaid agency to review HMOs with Medicaid products. Some New Jersey HMOs with Medicaid products have chosen to have the PRO also review their commercial side, while others have chosen to have a different review organization, usually NCQA, for their commercial business.

Sanctions for Failure to Meet Accreditation or External Quality Review Requirements

The majority of state regulations do not include specific sanctions for an HMO's failure to undergo an accreditation survey or external quality review, or to obtain accreditation or a favorable review. Florida is an exception, with sanctions ranging from fines and temporary suspension of enrollment for failure to apply for accreditation or be surveyed within required time frames up to revocation of the HMO's certificate of authority for failure to obtain accreditation from a follow-up survey conducted subsequent to a failed survey. In states without specific sanctions, state officials may apply general sanctions, including implementation of corrective plans, fines, and ultimately denial, suspension, or revocation of an HMO's license or certificate of authority, for failure to meet any state HMO regulatory requirements.

Many of the state HMO accreditation and external quality review requirements were implemented quite recently. Consequently, few states have had experience dealing with failures to meet these requirements. Florida has fined one HMO for failure to obtain accreditation within the time frame required. In the first round of external quality reviews, some Kansas HMOs did not obtain a review within the required time frame and were assessed penalties; state officials now send reminder letters to help ensure compliance. One Pennsylvania HMO failed to achieve accreditation in an initial review because it was not conducting primary verification correctly, although it had an above-average quality assurance program. The problem was dealt with internally, and the HMO was accredited on a subsequent review.

A few state officials indicated that they do not anticipate a lack of compliance with their external quality review/accreditation requirements, but will handle any violations that do occur on a case-by-case basis. Several state regulators noted that denial of accreditation, or the

identification of significant quality problems in an HMO's external quality review, would cause them to examine an HMO's quality assurance program very carefully.

Deemed Compliance with State HMO Regulations for Accredited HMOs

Deemed compliance provisions in state regulations, which allow an HMO to use information from the HMO's accreditation survey as evidence that the HMO complies with an equivalent state regulation, are a means of reducing HMOs' regulatory burden and potential duplication of effort by the state and accrediting organizations. In the process of analyzing state HMO accreditation and external quality review requirements, five states were identified that have implemented regulations allowing accredited HMOs to be deemed in compliance with certain state HMO requirements: New Jersey, New Mexico, Ohio, Oklahoma, and Vermont (Table 2). Additional states where officials were interviewed, including West Virginia and Alabama, are considering implementation of regulations allowing deemed compliance for accredited HMOs. (This may not include all states with these regulations or proposed regulations, since not all states were surveyed.)

The five states identified require the HMO regulatory agency to evaluate the standards used by the accrediting organization and to determine that these standards are equivalent to the state HMO standards. New Mexico allows deemed compliance with credentialing, utilization management, and performance and outcome measurement requirements, and Ohio allows deemed compliance with quality assurance and utilization management requirements.

Because the passage of deemed compliance provisions has been so recent, states have had limited experience with implementation. The state regulators interviewed were generally supportive of deemed compliance provisions, but cautioned that they will continue to exercise regulatory authority over accredited HMOs as necessary. Regulators in some states noted that a

Table 2

States Allowing Deemed Compliance with HMO Regulations for Accredited HMOs¹

State	Description of Regulation	Effective Date
New Jersey	If an HMO attains “accreditation” or “certification” or other such status granted by the external quality review organization (EQRO) within the 12 months prior to the Department’s comprehensive assessment review, the HMO shall be exempted from examination by the Department in any area in which the Commissioner determines that the EQRO’s review demonstrated specific compliance with standards substantially equivalent to those in state HMO regulations. (N.J.A.C. 8:37-7.2(c))	March 1997
New Mexico	An MHCP may submit accreditation by a nationally recognized accrediting entity as evidence of compliance with the credentialing, utilization management, and performance and outcome measurement requirements in state HMO regulations. The MHCP may be deemed to have met the relevant state requirements where comparable standards exist, and the private accrediting agency is recognized and approved by the Superintendent. (12 NMAC 10.13.11, 10.19.5, 10.20.10)	March 1997
Ohio	A health insuring corporation may present evidence of compliance with state requirements for a quality assurance program and for utilization review by submitting certification to the Superintendent of Insurance of its accreditation by an independent, private accrediting organization. Upon review of the organization’s accreditation process, the Superintendent may determine that accreditation constitutes compliance with the requirements. (ORC, Sections 1751.75 and 1751.83)	October 1998
Oklahoma	The Commissioner shall treat a managed care plan as meeting a specific state standard if the plan is accredited by a national private accreditation body recognized by the Commissioner, and the Commissioner finds that the specific state standard is at least equivalent to a requirement used by the national private accreditation body in accrediting the managed care plan. (O.A.C. 310:656-3-2)	1997
Vermont	Each managed care plan shall, on a continual basis, evaluate the quality of health and medical care provided to its members in Vermont. A managed care plan may fulfill this requirement through an independent accreditation organization approved by the Department as capable of analyzing, in an in-depth manner, a managed care plan’s provision of quality of health and medical care to its members. (HCA Rule 10,000, Section 10.204)	1997

¹ These states were identified in the process of analyzing state hmo accreditation and external quality review requirements, so the list may not include all states with regulations allowing accredited HMOs to be deemed in compliance with certain state HMO requirements.

number of NCQA accrediting standards are equivalent to or more comprehensive than state standards. However, a few regulators cited examples where state standards are stricter than comparable accreditation standards; for example, one state requires a complete work history from HMO participating physicians rather than five years of history, and another requires more frequent examination of HMOs' credentialing processes.

Implications for HMOs Serving Rural Areas

Clearly, an accreditation requirement will have a greater impact on HMOs that were not previously accredited and would not have applied for accreditation in the absence of such a requirement. An HMO may have made the decision not to seek accreditation previously because of a lack of competitive pressures for accreditation in its market area, the cost of accreditation, the HMO's judgment that it lacked the necessary resources to devote to the accreditation process, concern about the potential outcome of the accreditation review, or a combination of these reasons.

HMOs that serve rural areas range from small regionally based HMOs whose enrollment is predominantly rural to large urban-based HMOs whose rural enrollment is a relatively small proportion of their total enrollment. The market areas of HMOs with large proportions of rural populations are characterized by fewer large employers, lower HMO penetration rates, and smaller numbers of competing HMOs, suggesting that these HMOs face less competitive pressures for accreditation than HMOs with moderate rural proportions. HMOs with large proportions of their service area populations in rural areas are, in fact, significantly less likely to apply for NCQA accreditation than those with moderate rural proportions, controlling for several HMO organizational and market area characteristics (Casey and Brasure, 1998).

In addition to the rural proportion of an HMO's service area population, several other HMO characteristics are significantly related to the probability of applying for NCQA accreditation. HMO size, affiliation, federal qualification, and age, the HMO market penetration rate, and operation in a state with HMO accreditation requirements are all significantly and positively related to the probability of applying for NCQA accreditation (Casey and Brasure, 1998). These significant relationships suggest that state HMO accreditation requirements may affect which types of HMOs enter rural markets. They may, for example, promote the expansion of larger, nationally affiliated HMOs that have a history of accreditation. These requirements may be additional deterrents to the development of small, regionally based HMOs that have more limited financial and organizational resources to bring to the accreditation process.

Medicaid enrollment as a proportion of an HMO's total enrollment is significantly and negatively related to the probability of applying for accreditation (Casey and Brasure, 1998). HMO accreditation requirements may conflict with efforts to expand rural Medicaid and Medicare managed care enrollment, particularly if they are applied to nontraditional plans that primarily or exclusively serve Medicaid or Medicare beneficiaries. These plans are likely to have limited resources to devote to the accreditation process.

External quality reviews conducted by an accrediting or review organization using state standards, such as those required by Kansas and Nevada, are comparable to HMO quality reviews conducted by state regulators in some other states. In contrast, state regulations that require an HMO to apply for or receive accreditation from an approved accrediting organization are likely to necessitate a significantly greater commitment of resources from the HMO, especially if it is required to achieve a certain level of accreditation. Consequently, this type of

requirement has much greater potential impact on HMOs that have limited resources, for example, new, small, regionally based HMOs.

Currently, the majority of accredited HMOs are accredited by NCQA. NCQA requires HMOs to be at least eighteen months old before applying for accreditation, and HMOs less than two years old are significantly less likely to apply for NCQA accreditation than older HMOs (Casey and Brasure, 1998). Most of the states with HMO accreditation or external review requirements require HMOs to apply for accreditation or obtain an external review within two to three years from the date of initial licensure. The relatively short time frame for meeting these requirements compels new HMOs to seek accreditation sooner than they might have done in the absence of such a requirement, and may be an additional deterrent to the development of new HMOs in rural areas not previously served by HMOs.

In the states with HMO accreditation or external review requirements, the number of approved accrediting or review organizations ranges from one to five. Restricting HMOs to one accrediting or review organization may make it easier for state HMO regulators to develop and maintain expertise about that organization's accreditation or review process. However, allowing HMOs to choose among multiple accrediting or review organizations permits HMOs with different characteristics, for example, size, age, model type, and proportion of rural enrollees, to select the accreditation or review process that they believe is best suited to the HMO's structure, resources, and needs.

STATE REQUIREMENTS THAT AN HMO BE ACCREDITED AS A CONDITION OF SERVING STATE EMPLOYEES

Accreditation Requirements for HMOs Serving State Employees

Our analysis and interviews indicate that four states have implemented, or are in the process of implementing, requirements that an HMO be accredited in order to serve state

employees: Alabama, Iowa, Ohio, and Tennessee (Table 3). A fifth state, New York, had initially decided in 1995 to phase in a requirement that HMOs serving state employees be NCQA accredited. However, New York State's Joint Labor Management Committee has since moved away from requiring accreditation. The state's request for proposals (RFP) for health plans to serve state employees asks HMOs to provide information about their current NCQA accreditation status and their accreditation status from other national recognized accreditation organizations. This information is one factor considered in selecting HMOs, and most HMOs currently serving state employees are NCQA accredited, but accreditation is not required.

The State Employee Insurance Board in Alabama began requiring HMOs serving state employees to be NCQA accredited in 1997. The Board's contracts with HMOs require the HMO to have NCQA accreditation by January 1, 1998, and place 10 percent of the HMO's total annual premium at risk for failure to meet this standard. The Board currently contracts with four HMOs that together serve about 5 percent of state employees. As of September 1998, none of the four HMOs had obtained NCQA accreditation. As provided in its contracts, the Board is withholding a portion of premiums for the two older HMOs, and has the two newer HMOs on a schedule to obtain accreditation.

In Iowa, the HMO accreditation requirement is being implemented by state regulation. HMOs seeking approval to offer benefits to state employees must be accredited by NCQA or JCAHO for the benefit year beginning in January 2001 (Chapter 581, Section 15.1(3)). The requirement may be waived for up to two consecutive benefit years for an unaccredited HMO seeking approval to offer benefits to state employees for the first time, if the HMO provides clear evidence of its intent to receive the required accreditation." The original time frame for implementation of the accreditation requirement was 1999. However, earlier this year, the

Table 3

State HMO Accreditation Requirements for HMOs Serving State Employees

State	Requirement	Effective Date	Approved Accrediting Organizations
Alabama	The State Employee Insurance Board's quality assurance/quality improvement standard in its contracts with HMOs states that the HMO must have NCQA accreditation by January 1, 1998. The contract provides that 10% of the HMO's total annual premium is at risk for failure to meet this standard, with the penalty to be assessed on a monthly basis	January 1, 1998	NCQA
Iowa	Beginning with the benefit year starting January 1, 2001, any HMO or ODS seeking approval to offer benefits to state employees shall provide evidence of accreditation by NCQA or JCAHO. Where an HMO or ODS seeks approval to offer benefits to state employees for the first time and has not received the required accreditation, the department will waive the requirement for up to 2 consecutive benefit years providing the HMO or ODS provides clear evidence of its intent to receive the required accreditation.	January 1, 2001	JCAHO, NCQA
Ohio	HMOs serving state employees must be NCQA accredited, with an accreditation status of full or one-year. This is a contracting requirements that was agreed upon by the State of Ohio and unions representing state employees.	November 1997	NCQA
Tennessee	HMOs serving state employees must be NCQA accredited, or become accredited within two years of contracting with the state to serve state employees. This is a state Division Insurance Administration contracting requirement.	1995	NCQA

Department of Personnel proposed a rule change delaying the date to 2001 to give HMOs more time to comply with the requirement.

Currently, the Iowa Department of Personnel contracts with HMOs to serve state employees on a county-by-county basis. Two Blue Cross products, a fee-for-service product and a PPO product, are offered statewide to state employees, but no HMOs are offered statewide. The Department would like to see a statewide HMO product offered to state employees, and is considering potential options for encouraging HMOs to serve additional rural counties, including the possibility of combining its HMO bidding process with Medicaid bidding in the future. The Department recognizes that the HMO accreditation requirement may eliminate some HMOs from the State Employees Health Insurance Program in the future, and plans to monitor its impact.

As of 1997, HMOs serving state employees in Ohio were required to be NCQA accredited, with a status of full or one-year accreditation. There are no exceptions for new HMOs. The Ohio Department of Administrative Services contracts with HMOs to serve state employees on a county-by-county basis, and also has adopted a policy of limiting the number of HMOs with which the State contracts to five HMOs per county. A PPO option is offered in all counties, and about 40 percent of state employees chose the PPO. A total of nineteen HMO options are offered, with one to five HMO offerings per county. Three of the NCQA-accredited HMOs offered to state employees have large statewide networks, and most rural counties have two or more HMO offerings. Implementation of the accreditation requirement may have reduced the number of HMOs applying to serve state employees. However, the state does not view this as a problem, given the large number of accredited HMOs in Ohio, and the five-HMOs-per-county limit it has imposed.

In Tennessee, state contracting procedures require HMOs serving state employees to be NCQA accredited or become accredited within two years of contracting with the state; this policy began in 1995. Currently, the Division of Insurance Administration offers PPO, point of service (POS), and HMO plans to state employees. About 57 percent of state employees are enrolled in the PPO plan, 7 percent in the POS plan (it is the first year of offering this plan), and 36 percent in HMOs. The Division contracts with five HMOs, all of which are accredited or scheduled for an accreditation review.

Implications for HMOs Serving Rural Areas

Accreditation requirements for HMOs that serve state employees have less critical implications for HMOs serving rural areas than accreditation and external review requirements linked to licensure. In states that have an accreditation requirement for HMOs to serve state employees, an unaccredited HMO cannot bid on state employee contracts, but may still operate as an HMO. It should also be noted that accreditation is not a guarantee of receiving a contract to serve state employees, but is one of several factors that these states use to select health plans.

Although state employee HMO accreditation requirements are less important than accreditation and external quality review requirements linked to licensure, they do have significance for HMOs serving rural areas. While many state employees live and work in urban population centers, a substantial number are employed in rural areas in correctional institutions, mental health facilities, and regional offices of state agencies (e.g., departments of transportation and natural resources), especially in predominantly rural states. Thus, state employees can be a desirable employer group for HMOs serving rural areas, both because of the size of the group and because having a state contract will encourage other rural employers to contract with the HMO. From a state's perspective, offering a managed care option to rural state employees may

be a way to demonstrate the feasibility of managed care in rural areas, in addition to reducing costs and expanding coverage for state employees (Christianson and Hart, 1997).

Obviously, the potential impact of a state employee HMO accreditation requirement on HMOs serving rural areas will vary depending on what the content of the requirement is and how it is implemented. It will also depend on the number of state employees in rural areas and the number of accredited HMOs that are serving rural areas. For example, an HMO may choose not to bid on the state employee contract rather than obtain accreditation. If that HMO is one of several HMOs serving rural state employees and the other HMOs are all accredited, enrollees in that HMO will have to change plans, but will still be able to choose an HMO. The implications are very different if the HMO that chooses not to bid is the only HMO with a significant rural presence and its absence will eliminate an HMO option for rural state employees. The potential impact on employees will obviously be greater if the HMO plan differs significantly from the other health plan options in terms of benefits and costs to the employee (e.g., coverage of preventive services and amount of copayments and deductibles).

CONCLUSION

States are taking steps to address some of the policy issues raised by incorporation of HMO accreditation and external quality review requirements into state HMO licensure processes and state employee contracting. Some states, for example, have adopted regulatory provisions that allow accredited HMOs to be deemed in compliance with equivalent state regulations. Other policy questions, however, have not been addressed; and many accreditation requirements are still in the early stages of implementation, so there has been limited experience to assess their impact.

As states gain more experience in implementing HMO accreditation and external quality review requirements, it will be especially important to evaluate the rural impact of these requirements. Several states that have incorporated HMO accreditation or external quality review requirements into their HMO licensure processes have significant rural populations, for example, Oklahoma, Pennsylvania, South Carolina, and West Virginia. The states with state employee HMO accreditation requirements, Alabama, Iowa, Ohio, and Tennessee, also have substantial rural populations. These states will provide opportunities to evaluate the impact of these requirements on HMOs serving rural areas, rural providers, and rural consumers.

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APPENDIX A

National Accrediting Organizations for HMOs and Other Managed Care Organizations

Accreditation Association for Ambulatory Health Care (AAAHC)

Incorporated in 1979, AAAHC accredits a wide range of ambulatory health care organizations, including ambulatory clinics and surgery centers, single and multi-specialty group practices, community health centers, urgent and intermediate care centers, HMOs, and IPAs. The AAAHC accreditation process involves an organizational self-assessment and an on-site survey conducted by a team of physicians, health care managers and other health care professionals, using core standards in the following areas: rights of patients, governance, administration, quality of care, quality management and improvement, clinical records, professional improvement, and facilities and environment (AAAHC, 1998a). As of September 1998, 12 HMOs were accredited by AAAHC (AAAHC, 1998b).

American Accreditation Healthcare Commission/Utilization Review Accreditation Commission (URAC)

Founded in 1990, URAC offers accreditation programs in the following areas: credentials verification organization, health utilization management, health networks, health care practitioner credentialing, telephone triage and health information, workers' compensation utilization management, and workers' compensation networks. The URAC accreditation process includes a detailed analysis of an applicant's policies and procedures, as well as on-site verifications (URAC, 1998). URAC employs a "modular" approach to accreditation, which allows MCOs to seek accreditation only for the functions they perform, and also permits MCOs to achieve comprehensive accreditation gradually, one element at a time. URAC's largest accreditation program is health utilization management. As of August 1, 1998, sixteen health plans had health network accreditation from URAC (URAC, 1998).

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

JCAHO began evaluating hospitals in 1951, and currently provides evaluation and accreditation services for hospitals, home care organizations, long-term care facilities, behavioral health care organizations, ambulatory care providers, clinical laboratories, and health care networks, including HMOs and preferred provider organizations (PPOs) (JCAHO, 1998a). HMOs and PPOs are accredited under JCAHO's accreditation program for health care networks, which began in 1994. The eight categories of network standards are: 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 (JCAHO, 1996). The network standards largely address issues of network-wide integration, coordination, and accountability not covered by the accreditation standards for individual network components that are accredited by JCAHO, e.g., hospitals and long-term care

facilities. Network components that are not accredited by JCAHO or another accrediting body recognized by JCAHO are surveyed as part of the network accreditation process. As of September 1998, thirty-six health care systems and managed care organizations were accredited by JCAHO through the network accreditation process (JCAHO, 1998b).

The National Committee for Quality Assurance (NCQA)

NCQA began accrediting MCOs in 1991. NCQA evaluates plan performance using accreditation standards in six categories: quality assurance/improvement; credentialing; members' rights and responsibilities; utilization management; preventive health services; and medical records. During an on-site accreditation survey, an NCQA team composed of physicians and administrators with managed care expertise reviews an MCO's quality-related systems and assesses the extent to which these systems are in compliance with NCQA standards. Possible accreditation decisions include full (three-year) accreditation, one-year accreditation, provisional accreditation, and denial. NCQA is also responsible for the continued development of the Health Plan Employer Data and Information Set (HEDIS), a set of standardized performance measures designed to provide purchasers and consumers with information to compare the performance of MCOs. Beginning in 1999, NCQA will base 75 percent of a plan's accreditation score on its degree of compliance with NCQA standards and 25 percent of the plan's score on its audited results for a selected set of HEDIS performance measures. As of August 31, 1998, 260 health plans were accredited by NCQA (NCQA, 1998).