Quality Improvement (QI) Proposed Updates

QI 2: Health Services Contracting

The organization's contracts with individual practitioners and providers, including those making UM decisions, specify that contractors cooperate with its QI program.

Intent

The organization's contracts with practitioners and providers foster open communication and cooperation with QI activities.

Element C: Bidirectional Behavioral Health Data Sharing Arrangements

The organization demonstrates that it has at least one arrangement with a behavioral health care organization to bidirectionally exchange data for HEDIS measure performance.

Scoring

Met	Partially Met	Not Met
The organization meets the requirement	No scoring option	The organization does not meet the requirement

Data source

Reports

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

NCQA reviews and scores this element for each product line brought forward for Accreditation.

Documentation

For First Surveys and Renewal Surveys: NCQA reviews one active contract, or reviews only relevant pages from the contract that addresses the element (e.g., the first page with the practitioner or entity name, text that addresses the element and signature page).

Look-back period

For First Surveys and Renewal Surveys: At least once during the prior 12 months.

Explanation

This element may not be delegated.

The organization demonstrates that it has at least one arrangement with a behavioral health care organization to bidirectionally share (i.e., both parties exchange information) all data required for its use of at least one of the following HEDIS measures, as specified in *HEDIS Volume 2*: *Technical Specifications for Health Plans (including Allowable Adjustments):*

- Follow-Up After Hospitalization for Mental Illness (FUH).
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET).
- Follow-Up Care for Children Prescribed ADHD Medication (Continuation and Maintenance) (ADD-E).
- Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E).

- Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA).
- Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD).
- Plan All-Cause Readmissions (PCR).

The arrangement may address reporting of the HEDIS measure, or its modified use, and must describe:

- The selected HEDIS measure(s).
- The method of data exchange.
- The frequency of data exchange.

The organization and behavioral healthcare organization determine the measure(s), methods and frequency of data exchange.

Exception

This element is NA if the plan does not contract with behavioral health organizations.

QI 4: Data Exchange and Usability Strategy

Intent

The organization develops a strategy for achieving and sustaining data exchange and usability that aligns with national standards and regulatory requirements.

Element A: Data Exchange and Usability Strategy Description

The organization's data exchange and usability strategy (i.e., interoperability) describes:

1. **Objectives for business transformation use cases.**
2. **Governance and staff integration.**
3. **Application programming interface (API) implementation plan.**

Scoring

Met	Partially Met	Not Met
The organization meets 3 factors	The organization meets 2-3 factors	The organization meets 0-1 factors

Data source Documented process

Scope of review

Product lines

This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.

Documentation

For Interim Surveys: NCQA reviews the organization's documented process.

For First and Renewal Surveys:

Look-back period For All Surveys: Prior to the survey date.

Explanation

Interoperability is the ability of information systems, devices and applications to access, exchange, integrate and use data in a coordinated manner, in and across organizational, regional and national boundaries, to provide timely and seamless portability of information and optimize the health of individuals and populations globally.

Health data exchange architectures, application interfaces and standards enable data to be accessed and shared across the complete spectrum of care, in all applicable settings and with relevant stakeholders, including patients.

Mandated implementations, outlined by states and the federal government, require organizations to implement systems that allow seamless exchange of patient data across platforms.

Business use cases are the byproduct of information exchange and cooperative effort, without manual intervention, to advance fundamental processes such as quality improvement or care coordination.

Factor 1: Objectives

The organization outlines one of the following business use cases in its strategy:

- Quality measurement and improvement.
- Care coordination.
- Improved data exchange coverage.
- Expanding the universe of data collected and integrated through health information exchanges/networks.
- Provider performance reporting.

Factor 2: Governance and staff integration

Engagement and collaboration between organization departments are critical to effective interoperability governance. Aligning internal business units to the goals and objectives of the interoperability strategy helps ensure effective implementation of business use cases (factor 1).

Interoperability governance refers to the ability to monitor and make decisions about interoperability frameworks, institutional arrangements, organizational structures, roles and responsibilities, policies, agreements and other aspects of interoperability.

The organization's strategy for governance includes:

- The staff responsible for translating mandated implementations into internal business use cases.
- The types of information reported to senior-level staff.
- The senior-level staff responsible for:
- Data management.
- Regulatory compliance.
- Incident reporting and responses.
- Patient privacy.

Factor 3: API Implementation plan

The organization develops implementation plans to address the following regulated APIs:

- Patient Access FHIR API. The organization describes its implementation plan for an HL7® FHIR® Patient Access API that enables patients to access all data the organization has collected on them, including administrative and supplemental data from third parties.
- Provider Access FHIR API. The organization describes its implementation plan for an HL7 FHIR Provider Access API that enables in-network providers to acquire the organization's data on patients they have a treatment relationship with.
- Prior Authorization FHIR API. The organization describes its implementation plan for a Prior Authorization API.
- Payer-to-Payer FHIR API. The organization describes its implementation plan for an HL7 FHIR Payer Access API that enables payers to acquire the organization's data on patients they have a relationship with.

Proposed Population Health Management Updates

Population Health Management

PHM 1: PHM Strategy

The organization outlines its population health management (PHM) strategy for meeting the care needs of its member population.

Intent

The organization has a cohesive plan of action for addressing member needs across the continuum of care.

Element A: Strategy Description

The strategy describes:

1. **Goals and populations targeted for each of the four areas of focus.***
2. **Programs or services offered to members.**
3. **~~Activities that are not direct member interventions.~~ At least t~~-~~Three activities that support practitioners, providers or community-based organizations.**
4. **How member programs are coordinated.**
5. **How members and practitioners are informed about available PHM programs.**
6. **How the organization promotes health equity.**

Critical factors: Score cannot exceed Partially Met if one critical factor is scored "No."

Scoring

Met	Partially Met	Not Met
The organization meets 5 ~~4~~-6 factors	The organization meets 3-4 factors	The organization meets 0-2 factors

Data source Documented process

Scope of review

Product lines

This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.

NCQA reviews and scores this element for each product line brought forward for Accreditation.

Documentation

NCQA reviews a description of the organization's comprehensive PHM strategy that is in place throughout the look-back period. The strategy may be fully described in one document or the organization may provide a summary document with references or links to supporting documents provided in other PHM elements. The organization may use a single document to describe a strategy that applies across all product lines, if the document also describes differences in strategy to support different populations, by product line.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

This element is a **structural requirement**. The organization must present its own materials.

Factor 1 is a critical factor; if this critical factor is scored "No," the organization's score cannot exceed "Partially Met" for the element.

Factors 1, 2: **Four areas of focus**

The organization has a comprehensive strategy for population health management that must address member needs in the following four areas of focus:

- Keeping members healthy.
- Managing members with emerging risk.
- Patient safety or outcomes across settings.
- Managing multiple chronic illnesses.

The description includes the following for each of the four areas of focus:

- A goal (factor 1).
- A target population (factor 1).
- A program or service (factor 2).

Goals are measurable, time-targeted and specific to a target population. A **program** is a collection of services or activities to manage member health. A **service** is an activity or intervention in which individuals can participate to help reach a specified health goal.

***Factor 2*: Programs and services**

Programs and services offered to the organization's members align with its comprehensive strategy and the areas of focus in factor 1.

NCQA does not prescribe a specific number of programs or services that must be offered to members, nor does it require all programs and services to be included or limited to each focus area in factor 1. The organization must include a description of the programs and services that align with the goals in its comprehensive PHM strategy, including those programs and services involving any level of member interactive contact.

Factor 3: ~~**Activities that are not direct member interventions**~~ **Activities that support practitioners, providers or community-based organizations**

The organization's strategy includes and describes ~~the~~ at least three activities ~~it offers in its PHM strategy, including activities not directed at individual members~~ aimed at supporting practitioners, ~~and/or~~ providers or community-based organizations:

1. Share actionable data with practitioners to support the four areas of focus in the strategy. Refer to *PHM 3: Delivery System Supports* Element A for details about expectations related to this activity.
2. Promote and enable accurate and efficient patient attribution under alternative payment model arrangements.

3. Collaborate with practitioners or providers to establish agreed-upon benchmarking methodology and approach under alternative payment model arrangements.
4. Provide quality measures, methodologies and performance targets at the beginning of the performance period and regularly thereafter.
5. Provide transformation support to primary care practices (e.g., PCMHs). Refer to PHM 3, Element B for details about expectations related to this activity.
6. Collaborate with community-based organizations (e.g., LTSS providers) to improve transitions of care from the post-acute setting to the home, or integrate community health workers (CHW) in the program or in care delivery.
7. Collaborate with hospitals to improve care transitions and reduce readmissions.

Practitioners, providers or community-based organizations include those that deliver clinical, behavioral health or non-clinical care and services.

~~The organization has at least one activity in place that supports the PHM strategy. The activity may be specific to one area of focus or may apply to more than one area of focus.~~

~~NCQA does not prescribe a specific number of activities that must be offered to members, nor must all activities unrelated to the PHM strategy be included or limited to each focus area in factor 1. The organization must include a description of all activities that align with the goals in its comprehensive PHM strategy.~~

Factor 4: **Coordination of member programs**

The organization coordinates programs or services it directs and those facilitated by providers, external management programs and other entities. The PHM strategy describes how the organization coordinates programs across settings, providers and levels of care to minimize confusion for members who are contacted by multiple sources. Coordination activities are not required to be exclusive to one area of focus and may apply across the continuum of care and to initiatives in other organizations.

Factor 5: **Informing members**

The PHM strategy describes the organization's process for informing members and practitioners about available PHM programs and services, regardless of level of contact. The organization may make the information available on its website; by mail, email, text or other mobile application; by telephone; or in person.

The organization communicates the information to members by mail, telephone or in person. The organization may use its network practitioners to inform members. NCQA does not consider this to be delegation.

Factor 6: **Promote health equity**

The World Health Organization defines health equity as “the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically.”

The organization has a comprehensive PHM strategy that describes its commitment to improving health equity and describes a plan for at least one action that promotes equity in management of member care. The plan includes a detailed description of action(s) the organization will take and a timeline for implementation.

Exceptions

None.

Examples

***Factors 1, 2:* Goals, target populations, opportunities, programs or services**

Keeping members healthy

Seasonal Influenza Vaccinations: This program focuses on providing children and adult members with their annual influenza vaccinations.

- *Program goal:* 55% of members in the target population report receiving annual influenza vaccinations within 12 months of enrollment.
- *Target population:* Children 5–17; adults 18 or older with no risk factors.
- *Programs or services:*
  - Distribute free influenza vaccinations at:
    - Community flu clinics (e.g., churches, recreation centers).
    - Mobile and drive-thru clinics.
    - Local pharmacies.
  - Send email and mail reminders.
  - Create radio and TV advertisement reminders to get vaccinated.

Managing members with emerging risk

Future Moms: Maternity program focused on providing care and treatment for high-risk maternity cases. The program helps expectant mothers focus on early prenatal interventions, risk assessments and education.

- *Program goal:* 90% of members 18–45 years identified as potential high-risk for pregnancy complications will enroll in the program within the next ~~1~~2 months *from the date of identification.*
- *Target population:* Members 18–45 with an OB/GYN claim and other medical or pharmacy data that stratify them into high risk for pregnancy complications.
- *Programs or services:*
  - Prenatal and newborn education classes.
  - Lactation consultations.
  - Breastfeeding support groups.
  - Workshops on preventing preeclampsia.
  - Literature and follow-up appointments for recovery after emergency cesarean.

Patient safety

Combating Hospital-Acquired Infections: This program focuses on educating members to reduce the rate of hospital-acquired infections.

- *Program goal:* Improve clinical safety by reducing hospital-acquired infections by 5% over 3 years.
- *Target population:* Members receiving in-patient surgical procedures.
- *Programs or services:*

- Distribute educational materials about proper hand hygiene, signs and symptoms of infection and when to seek care.
- Post-discharge follow-up to confirm members receipt of post-surgical care instructions.

Outcomes across settings

Preventing Hospital Readmissions: This program provides focused care management services to members identified as high risk for readmission.

- *Program goal:* 75th percentile of clinical HEDIS® goal of Quality Compass® for Ambulatory Follow-Up After Emergency Department Visit for Mental Illness within 6 months.
- *Target population:* Members 18 or older admitted within the past 90 days who were diagnosed with a behavioral health disorder or mental illness.
- *Programs or services:*
  - Weekly outreach from nurse care manager who:
    - Completes post-discharge assessment and creates member goals and interventions.
    - Performs medication reconciliation and encourages medication adherence.
    - Confirms follow-up appointment.

Managing multiple chronic illnesses

Population Health Management: This program is designed to help maximize health status, improve health outcomes and reduce health care costs for members diagnosed with asthma (adult), diabetes (types 1 and 2, adult), coronary artery disease, heart failure and chronic obstructive pulmonary disease.

- *Program goal:* 95% of members with a chronic illness report improved self-management of their illness on patient-reported outcome surveys within 24 months of enrollment.
- *Target population:* Members 18–65 who have more than one chronic illness, identified through claims, lab and pharmacy data.
- *Programs or services:*
  - 24-hour inbound calling program: Informs members of identified gaps in care and actions to improve overall health.
  - Health Information Profile tool: Dynamic resource that captures and houses a member's medical history, medication, self-monitoring and control/prevention information.
  - Mobile app with community support networks, condition-specific management education, trigger-tracking and on-demand coaching.

Factor 3: ~~**Activities that are not direct member interventions**~~ **Activities that support practitioners, providers or community based organizations**

Approaches to enable accurate and efficient patient attribution organizations could consider:

- Claims-based attribution.
- Voluntary patient selection
- Automatic new-member attribution.

~~8. Sharing data and information with practitioners.~~

~~9. Interacting with and integrating delivery systems (e.g., contract with accountable care organizations [ACO]).~~

~~10. Providing technology support to or integrating with patient-centered medical homes (PCMH).~~

~~11. Integrating with community resources.~~

~~12. Value-based payment (VBP) arrangements.~~

~~13. Collaborating with community-based organizations and hospitals to improve transitions of care from the post-acute setting to the home.~~

~~14. Collaborating with hospitals to improve patient safety.~~

Factor 4: **Coordination of member programs**

- Coordinate care for hospitalized members between inpatient case management and transition of care programs.
- Share data with providers to coordinate closure of care gaps.
- Determine member eligibility in multiple programs and coordinate between programs to avoid duplication of services or member contacts.

Element B: Informing Members

The organization informs members eligible for programs that include interactive contact:

1. **How members become eligible to participate.**
2. **How to use program services.**
3. **How to opt in or opt out of the program.**

Scoring

Met	Partially Met	Not Met
The organization meets ~~3~~2~~-~~3 factors	The organization meets 2 factors ~~No scoring option~~	The organization meets 0-1 factors

Data source Documented process, Materials

Scope of review

Product lines

This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.

NCQA reviews and scores this element for each program brought forward for Accreditation. The score for this element is the average of the scores for all programs or services.

Documentation

For Interim Surveys: NCQA reviews the organization's documented process in effect during the look-back period from up to four randomly selected programs or services that involve interactive contact, or reviews all programs if the organization has fewer than four.

For First Surveys and Renewal Surveys: NCQA reviews materials used to communicate with members from up to four randomly selected programs or services

that involve interactive contact, or reviews all programs if the organization has fewer than four.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

This element applies to PHM programs or services in the PHM strategy that require interactive contact with members, including those offered directly by the organization.

Interactive contact

Programs with interactive contact have two-way interaction between the organization and the member, during which the member receives self-management support, health education or care coordination through one of the following methods:

- Telephone.
  - Text messaging.
- In-person contact (i.e., individual or group).
- Online contact:
  - Interactive web-based module.
  - Live chat.
  - Secure email.
  - Video conference.
- Interactive contact through artificial intelligence (e.g., voice activated technology).

Interactive contact does not include:

- Completion of a health appraisal.
- Contact to make an appointment, leave a message or verify receipt of materials.
- Contact to inform members of the availability of affinity programs (e.g., subsidized gym memberships, device purchases, discounted weight loss subscriptions).

Distribution of materials

The organization distributes information to members by mail, fax or email, or through messages to members' mobile devices, through real-time conversation or on its website, if it informs members that the information is available online through another method listed here. The notice communicating the information to members is available online must include a description specific enough to give readers a clear idea of the topic and the general content, and must include a link or directions to specific information. The organization may group or summarize information by theme.

The organization mails information to members who do not have fax, email, telephone, mobile device or internet access. If the organization uses telephone or other verbal conversations, it provides a transcript of the conversation or script used to guide the conversation.

The notice communicating that information is available online must include a description specific enough to give a clear idea of the site's topic and general content, and must include a link to specific information.

Factors 1–3: **Member information**

The organization provides eligible members with information on specific programs with interactive contact.

Exceptions

None.

Related information

Use of organizations that have interactive contact with members. Arrangements with contracted organizations to administer programs within the scope of the PHM strategy are considered delegation of PHM 1, Element B if those organizations perform the function required by this element and all delegation requirements apply, including oversight, even if PHM functions are not considered delegation because those specific functions are not in the scope of the standards.

Examples

- A summary or notes from a wellness program documenting a discussion between a health coach and a member or caretaker about how the member became eligible for the program, how to use the program and how to opt in or opt out.
- A call script for initial outreach by the organization:

  "Hello, <Member>! This is <Care Coordinator> from <Your Organization> and I'm calling because you are eligible for our Diabetes Management Program. We identify members for this program using medical and pharmacy data for services related to your condition. If you choose to participate in this program, you will receive <explain program services>. Are you interested in participating?"

  Member agrees: "Great! We will enroll you in the program. You should expect a welcome call from your assigned care manager in the next 2 business days. At that time, you can discuss how you prefer to communicate: by phone, text or video chat."

  Member declines: "No problem! You have the option to join this program at any time. If you change your mind, please call <Your Organization> Care Management Department at <number> or visit our website at <Your Organization>.org/DM/signup."
- A notice sent by mail, email, member account portal or text, inviting the member to contact the organization about their enrollment:

  Dear Member,

Because you had a recent hospital stay, you have been selected to participate in our Transitions Case Management Program. Sometime in the next 3 days, a nurse will call you to make sure you understand the instructions you were given when you left the hospital, and to make sure you have an appropriate provider to see for follow-up care. To contact the nurse directly, call 555-555-1234. If you do not want to participate in the Transitions Case Management Program, let us know by calling 555-123-4567.

- *Delegation example*

  The organization contracts with ABC PHM Company to provide telephone-based wellness coaching. As part of the arrangement, ABC PHM Company informs members of the information required in this element. Because the standards do not specifically review a wellness coaching function, NCQA does not consider review of the organization's delegation oversight for that function. However, because ABC PHM Company is performing the function required in PHM 1, Element B, the organization has delegated that function, and all delegation requirements apply, including oversight.

PHM 2: Population Identification

The organization systematically collects, integrates and assesses member data to inform its population health management programs.

Intent

The organization assesses the needs of its population and determines actionable categories for appropriate intervention.

Element A: Data Integration

The organization integrates the following data to use for population health management functions:

1. **Medical and behavioral claims or encounters.**
2. **Pharmacy claims.**
3. **Laboratory results.**
4. **Health appraisal results.**
5. **Electronic health records.**
6. **Health services programs within the organization.**
7. **Advanced data sources.**

Scoring

Met	Partially Met	Not Met
The organization meets 5-7 factors	The organization meets 2-4 factors	The organization meets 0-1 factors

Data source Documented process, Reports, Materials

Scope of review

Product lines

This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.

Documentation

For Interim Surveys: NCQA reviews the organization's documented process for the types and sources of integrated data.

For First and Renewal Surveys: NCQA reviews reports or materials (e.g., screenshots) for evidence that the organization integrated data types and data from sources listed in the factors. The organization may submit multiple examples that collectively demonstrate integration from all data types and sources, or may submit one example that demonstrates integration of all data types and sources.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

Data integration is combining data from multiple sources or databases. Data may be combined from multiple systems and sources (e.g., claims, pharmacy), and across care sites (e.g., inpatient, ambulatory, home) and domains (e.g., clinical, business, operational). ~~The organization may limit data integration to the minimum necessary to identify eligible members and determine and support their care needs.~~

Factor 1: **Claims or encounter data**

The organizations integrates both medical and behavioral health claims or encounters. Behavioral health claims data are not required if all purchasers of the organization’s services carve out behavioral healthcare services.

Factors 2, 3

No additional explanation required.

Factor 4: **Health appraisals**

The organization demonstrates the capability to integrate data from health appraisals and health appraisals should be integrated if elected by plan sponsor.

Factor 5: **Electronic health records**

Integrating EHR data for 10% of members meets the intent of this requirement.

Factor 6: **Health service programs within the organization.**

Relevant organization programs may include utilization management, care management or wellness coaching programs. The organization has a process for integrating relevant or necessary data from other programs to support identification

of eligible members and determining care needs. Health appraisal results do not meet this factor.

***Factor 7:* Advanced data sources**

~~Advanced data sources aggregate data from multiple entities such as all-payer claims systems, regional health information exchanges and other community collaboratives. The organization must have access to the data to meet the intent of this factor~~ To meet this requirement, the organization can access the data from one of the following sources:

- Regional, community or health system health information exchanges (HIE).
- All-payer databases.
- Integrated data warehouses between providers, practitioners and the organization, with all parties contributing to and using warehouse data.

Exceptions

None.

Related information

Data sources that meet factors 1–6 may not be used to meet factor 7.

A vendor relationship exists if the organization contracts with a NCQA-Prevalidated Health IT Solution to perform these functions.

Use of vendors for usability testing services. If the organization contracts with a vendor to provide usability testing services, it provides access to the vendor's documentation. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under *PHM 7: Delegation of PHM*. NCQA evaluates the vendor's documentation against the requirements. Refer to *Vendors* in *Appendix 2: Delegation and Automatic Credit Guidelines.*

Examples

***Factor 5:* EHR integration**

- Direct link from EHRs to data warehouse.
- Normalized data transfer or other method of transferring data from practitioner or provider EHRs.

***Factor 6:* Health services programs within the organization**

- Case management.
- UM programs.
  - Daily hospital census data captured through UM.
  - Diagnosis and treatment options based on prior authorization data.
- Disease management.
- Wellness coaching.
- Health information line.

~~***Factor 7:* Advanced data sources**~~

~~Advanced data sources may require two-way data transfer: The organization and other entities can submit data to the source, and can use data from the same source, including, but not limited to:~~

- ~~Regional, community or health system health information exchanges (HIE).~~
- ~~All-payer databases.~~
- ~~Integrated data warehouses between providers, practitioners, and the organization with all parties contributing to and using data from the warehouse.~~
- ~~State or regionwide immunization registries.~~

PHM 3: Delivery System Supports

The organization describes how it supports the delivery system, patient-centered medical homes and use of value-based payment arrangements.

Intent

The organization works with practitioners or providers to achieve population health management goals.

Element A: Data Sharing

The organization shares member data with practitioners or providers, including:

1. **Case management.**
2. **Utilization (Admissions, readmission, pharmacy, claims).**
3. **Quality data (performance results).**

Scoring

Met	Partially Met	Not Met
The organization meets 2-3 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Reports

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys.

Documentation

For First Surveys and *Renewal Surveys:* NCQA reviews evidence of monthly data sharing for each factor.

Look-back period

For First Surveys: prior to survey date.

For Renewal Surveys: prior to survey date.

Explanation **Data sharing** is transmission of member data from the health plan to the provider or practitioner that assists in delivering services, programs or care to the member.

Data sharing enables successful value-based care arrangements; it helps inform timely patient care decisions, quality performance and improvement and financial accountability. Organizations should strive to make data actionable and easily leveraged to inform care decisions. NCQA does not prescribe data-sharing methods, but encourages organizations to consider expanding their capabilities. For example, larger entities may prefer raw data, while smaller entities may prefer dashboards or other tools. The intent of this element is to enable meaningful data use.

Factor 1: **Case management**

The organization shares quarterly updates to member care management plans with practitioners to enable timely engagement, coordination and member management.

The organization shares monthly updates with practitioners for members in complex case management programs.

Factor 2: **Utilization (admissions, readmission, pharmacy, claims)**

The organization shares monthly utilization data to help inform appropriate follow-up, engagement and financial performance.

Factor 3: **Quality data (performance results).**

The organization shares monthly quality performance data on agreed-upon measures with participating practitioners.

Examples

Data sharing

- Sharing the patient-specific data listed below that the practitioner or provider does not have access to:
    - Pharmacy data.
    - ED reports.
    - Enrollment data.
    - Eligibility in the organization's intervention programs (e.g., enrollment in a wellness or complex case management program).
    - Reports on gaps in preventive services (e.g., a missed mammogram, need for a colonoscopy).
        - Claims data indicate if these services were not done; practitioners or staff can remind members to receive services.
    - Claims data.
    - Data generated by specialists, urgent care clinics or other care providers.
    - Lab results.
    - Social determinants of health assessment results.
    - Health appraisal results.
- Methods of data sharing:
    - Transmitted through electronic channels as "raw" data to practitioners who conduct data analysis to drive improved patient outcomes.

- Practitioner or provider portals that have accessible patient-specific data.
- Submit data to a regional HIE.
- Reports created for practitioners or providers about patients or the attributed population.
- A direct link to EHRs, to automatically populate recent claims for relevant information and alert practitioners or providers to changes in a patient's health status.
- Secure email or secure file transfer.

Element ~~A~~B: Practitioner or Provider Collaboration and Support

The organization supports practitioners or providers in its network to achieve population health management goals by:

1. ~~**Sharing data.**~~
2. ~~**Offering evidence-based or certified decision-making aids.**~~
1~~3~~. **Providing practice transformation support to primary care practitioners.**
2~~4~~. **Providing comparative quality information on selected specialties to inform high-value referrals.**
3. **Establishing clearly defined roles and responsibilities to achieve collaborative care management with provider partners.**
5. ~~**Providing comparative pricing information on selected services.**~~
4~~6~~. **Providing training on equity, cultural competency, bias, diversity or inclusion.**

Scoring

Met	Partially Met	Not Met
The organization meets 3~~3~~-4~~6~~ factors	The organization meets 2-3 factors.	The organization meets 0-1 factors

Data source Documented process, Reports, Materials

Scope of review

Product lines

This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.

Documentation

For Interim Surveys: NCQA reviews the organization's description of how it supports practitioners or providers.

For First Surveys and *Renewal Surveys:* NCQA reviews the organization's description of how it supports practitioners or providers that is in place throughout the look-back period.

NCQA also reviews materials demonstrating implementation at least once during the prior 24 months, or reviews reports showing the information if the support involves sharing or providing information or providing support.

For factor 3: NCQA reviews evidence that describes or shows a contractual arrangement between the parties and outlines care management responsibility and collaboration.

~~*For factor 2:* NCQA reviews materials for evidence that they were developed using established criteria or certified by a third-party entity.~~

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The organization identifies and implements activities that support and improve collaboration with practitioners and providers in meeting population health goals and moving to alternative payment model arrangements. Practitioners and providers may include accountable care entities, primary or specialty practitioners, PCMHs, or other providers included in the organization's network. Organizations may determine the practitioners or providers they support.

~~***Factor 1:* Data sharing~~

~~**Data sharing** is transmission of member data from the health plan to the provider or practitioner that assists in delivering services, programs or care to the member. The organization determines the frequency for sharing data.~~

~~***Factor 21:* Evidence-based or certified decision-making aids~~

~~**Shared decision-making (SDM) aids** provide information about treatment options and outcomes. SDM aids are designed to complement practitioner counselling, not replace it. SDM aids facilitate member and practitioner discussion on treatment decisions.~~

~~SDM aids may focus on preference-sensitive conditions, chronic case management or lifestyle changes, to encourage patient commitment to self-care and treatment regimens.~~

~~SDM aids are certified by a third party that evaluates quality, or are created using evidence-based criteria. If certified, the organization provides information about how, when, under what conditions and to whom certified SDM aids are offered. If created using evidence-based criteria, criteria must be cited. At least one certified or evidence-based SDM aid must be offered to meet the intent.~~

***Factor ~~31~~:* Practice transformation support**

Transformation support includes ~~movement~~ helping practices ~~to~~ become integrated or advanced ~~practice~~ (e.g., ACO, PCMH) and capable of entering ~~toward~~ alternative payment arrangements.

~~Practice Transformation activities extend beyond operational transformation and are intended as an accelerant to improve patient quality, access, and potentially preventable utilization and cost. The organization leverages data and internal subject matter expertise to offer targeted, recurring recommendations for performance improvement, and provides best practices, plan-sponsored member resources, and provider-specific action planning.~~

The organization provides documentation that it supports ~~the above definition~~ practice transformation in at least one of the following ways: ~~specifying the cadence and structure of engagement with practitioner-provider partners in quality-based contractual arrangements~~ .

- Practice transformation readiness assessment and financial incentives to enable transformation.
- Dashboards displaying quality, cost and utilization data to enable data-driven insights, such as monthly trends toward achieving agreed-upon quality metrics or comparison to other providers in network (i.e., peer comparison).
- Patient attribution reconciliation for entities entering alternative payment models.

Note: *~~The provision of performance reports alone does not satisfy the intent of this factor. Organizations should provide documentation demonstrating the extent of provider-facing engagement, relationship management, and resource alignment to support appropriate change implementation.~~*

Factor 43: **Comparative quality and cost information on selected specialties**

The organization provides comparative quality and, if available, cost information about selected specialties to practitioners or providers to help them make referral decisions. The organization provides comparative quality information about selected specialties to practitioners or providers and reports cost information if it is available. Comparative cost information may be cost or efficiency information and may be represented as relative rates or as a relative range.

Cost refers to a financial amount determined by using actual unit prices per service or unit prices in a standardized fee schedule.

Note: *For this factor, "specialties" and "specialty" refers to nonprimary care (specialties other than pediatrics, internal medicine and general or family medicine).*

~~***Factor 54:*** **Comparative pricing information for selected services**~~

~~**Price** is the actual monetary amount paid for a given service. The organization provides comparative pricing information to practitioners or providers to help them make referral decisions. Comparative pricing information may contain actual unit~~

~~prices per service or relative prices per service, compared across practitioners or providers.~~

~~To meet this requirement, the organization must provide comparative pricing information on at least one service, and show that it has provided the information to at least one provider that prescribes the service to members.~~

Factor 3: **Establishing agreed-upon roles and responsibilities**

The organization demonstrates it has implemented a process with participating practitioners for assigning primary accountability for member care management. NCQA does not prescribe which party is accountable (the plan or the practitioner); the goal is that patients have a coordinated, frictionless care management experience. The intent of this requirement is to prevent care fragmentation and patient abrasion due to lack of collaborative care management.

~~***Factor 65:*** **Training on language services or disability accommodations equity, culturally competency, bias, diversity or inclusion**~~

The organization ~~provides~~ offers at least one training to network practitioners on ~~health equity, including cultural competence, bias, diversity or inclusion.~~ provision of language services or use of disability accommodations (physical or communication-related) during health care encounters.

Language services include bilingual services, oral interpretation and written translation.

Exceptions

None.

Related information

Partners in Quality. The organization receives automatic credit for factor 3 if it is an NCQA-designated Partner in Quality.

The organization must provide documentation of its status.

Practice transformation support. In addition to a data-driven process for provider engagement that addresses patient needs and is intended to elevate quality-based contractual performance, the organization can support its practitioners or providers in meeting their population health management goals through any of the following methods:

- Incentive payments for PCMH arrangement.
- Technology support.
- Best practices.
- Supportive educational information, including webinars or other education sessions.

- Help with application fees for NCQA PCMH Recognition (beyond the NCQA program's sponsor discount).
- Help practices transform into a medical home.
- Provide incentives for NCQA PCMH Recognition (e.g., pay-for-performance).
- Use NCQA PCMH Recognition as a criterion for inclusion in a restricted or tiered network.

Use of vendors for training on cultural competency, bias or inclusion. If the organization contracts with a vendor to provide training on cultural competency, bias or inclusion for factor 6, it provides access to the vendor's documentation. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under *PHM 7: Delegation of PHM*. NCQA evaluates the vendor's documentation against the requirements. Refer to *Vendors* in *Appendix 2: Delegation and Automatic Credit Guidelines*.

Examples

~~***Factor 1:*** **Data sharing**~~

- ~~Sharing the patient-specific data listed below that the practitioner or provider does not have access to:~~
  - ~~Pharmacy data.~~
  - ~~ED reports.~~
  - ~~Enrollment data.~~
  - ~~Eligibility in the organization's intervention programs (e.g., enrollment in a wellness or complex case management program).~~
  - ~~Reports on gaps in preventive services (e.g., a missed mammogram, need for a colonoscopy).~~
    - ~~Claims data indicate if these services were not done; practitioners or staff can remind members to receive services.~~
  - ~~Claims data.~~
  - ~~Data generated by specialists, urgent care clinics or other care providers.~~
  - ~~Lab results.~~
  - ~~Social determinants of health assessment results.~~
  - ~~Health appraisal results.~~
- ~~Methods of data sharing:~~
  - ~~Transmitted through electronic channels as "raw" data to practitioners who conduct data analysis to drive improved patient outcomes.~~
  - ~~Practitioner or provider portals that have accessible patient-specific data.~~
  - ~~Submit data to a regional HIE.~~
  - ~~Reports created for practitioners or providers about patients or the attributed population.~~
  - ~~A direct link to EHRs, to automatically populate recent claims for relevant information and alert practitioners or providers to changes in a patient's health status.~~
  - ~~Secure email or secure file transfer.~~

~~***Factor 21:*** **Decision-making aids**~~

- ~~Certification bodies:~~

- ~~National Quality Forum.~~
- ~~Washington State Health Care Authority.~~

- ~~Methods of data sharing:~~
  - ~~Email PDF versions of certified or evidence-based shared decision aids to practitioners or providers.~~
  - ~~Notify providers how they can use the provider portal to access links to evidence-based shared decision aids.~~
  - A semiannual article in the organization's provider newsletter, describing available evidence-based SDM tools and how, when, under what conditions and to whom the tools should be offered.

Factor ~~3~~2: **Practice transformation support**

- Pay application fees for 50% of its primary care practices to earn PCMH Recognition.
- Supply staff, consultants or resources to help the practice with the transformation process.
- Facilitate recurring performance/QI discussions with providers, sharing current data and offering suggestions and resources as necessary, applicable and/or available.
- Notify practices that earning PCMH Recognition will make them eligible for ~~pay-for-performance~~ quality-based incentives.
- Support or finance efforts to establish a relationship with an accountable care organization (ACO).

Factor ~~4~~3: **Quality and cost information**

- Selected specialties:
  - Specialties to which a primary care practitioner refers members most frequently.
- Quality information:
  - Organization-developed performance measures based on evidence-based guidelines.
    - AHRQ patient safety indicators associated with a provider.
    - In-patient quality indicators.
    - Risk-adjusted measures of mortality, complications and readmission.
    - Quality Payment Program (QPP) measures.
    - Non-QPP Qualified Clinical Data Registry (QCDR) measures.
    - CAHPS Clinician and Group Survey.
    - The American Medical Association's Physician Consortium for Performance Improvement (PCPI) measures.
  - Cost information:
    - Relative cost of episode of care.
    - Relative cost of practitioner services.
    - In-office procedures.
    - Relative dollars per member per month (PMPM), overall or by type of service or dollars per procedure.
  - Care pattern reports that include quality and cost information.

- External cost-comparison databases with information about the potential cost of members seeking care out-of-network.

~~***Factor 54:*** **Pricing information**~~

- ~~Selected services:~~
  - ~~Services for which the organization has unit price information.~~
  - ~~Services commonly requested by primary care practitioners that are not conducted in-office.~~
  - ~~Radiology services.~~
  - ~~Outpatient procedures.~~
  - ~~Pharmaceutical costs.~~
  - ~~In-office procedures performed by specialty practitioners.~~
- ~~Pricing information:~~
  - ~~Types of pricing used for comparison:~~
  - ~~Price ranges or tiers.~~
  - ~~Bundled payments.~~
  - ~~Unit price.~~

Factor 6: **Training on equity, culturally competency, bias, diversity or inclusion**

- Delivery types:
  - Practitioner portal.
  - Newsletter or other practitioner communications during initial credentialing or recredentialing cycles.
- Practitioner training:
  - U.S. Department of Health and Human Services, Office of Minority Health has free, continuing education e-learning (Culturally and Linguistically Appropriate Services in Maternal Health Care, Behavioral Health, Oral Health) programs to help health care professionals provide culturally competent care.
- Training provided by Johns Hopkins University of Medicine Office of Diversity, Inclusion and Health Equity:
  - Unconscious Bias Collection (via LinkedIn Learning).

Element ~~B~~C: Alternative Payment Models ~~Value-Based Payment Arrangements~~

~~**The organization demonstrates that it has a value-based payment (VBP) arrangement and reports by reporting the percentages of total payments tied to VBP.**~~

The organization provides data on its portfolio of alternative payment models by reporting the following:

1. Pay for performance.
2. Shared savings.
3. Shared savings with downside risk.
4. Population-based payment.
5. Overall rate of payments tied to alternative payment models.

Scoring	Met	Partially Met	Not Met

~~The organization meets the requirement~~ The organization meets factors 1-5	No scoring option	The organization ~~does not meet the requirement~~ meets 0 factors

Data source Reports

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

NCQA reviews and scores this element for each product line brought forward for Accreditation.

Documentation

For First Surveys and Renewal Surveys: NCQA reviews the VBP worksheet to demonstrate that the organization has VBP arrangements in each product line. Worksheets reflect a continuous 12-month period within the look-back period.

Look-back period *For First Surveys and Renewal Surveys:* At least once during the prior 24 months.

Explanation This element may not be delegated.

There is broad consensus that payment models need to evolve from payment based on volume of services provided to models that consider value or outcomes. The fee-for-service (FFS) model does not adequately address the importance of non-visit-based care, care coordination and other functions that are proven to support achievement of population health goals.

~~The organization demonstrates that it has at least one VBP arrangement by reporting the percentage of total payments made to providers and practitioners associated with each type of VBP arrangement for a continuous 12-month period within the look-back period.~~

The organization uses the following ~~VBP types~~ alternative payment model types, sourced from the Health Care Payment Learning & Action Network categories. ~~*CMS Report to Congress: Alternative Payment Models and Medicare Advantage*~~ to report arrangements to NCQA. ~~The organization is not required to use them for internal purposes. If the organization uses different labels for its VBP arrangements, it categorizes them using the NCQA provided definitions.~~

Factor 1: **Pay-for-performance**

Payments are for individual units of service and triggered by care delivery, as under the FFS approach, but providers or practitioners can qualify for bonuses or be subject to penalties for cost- and/or quality-related performance. Foundational payments or payment for supplemental services also fall under this payment approach.

***Factor 2:* Shared savings**

Payments are FFS, but providers/practitioners who keep medical costs below the organization's established expectations retain a portion (up to 100%) of the savings generated. Providers/practitioners who qualify for a shared savings award must also meet standards for quality of care, which can influence the portion of total savings the provider/ or practitioner retains.

~~*Shared risk*: Payments are FFS, but providers/practitioners whose medical costs are above expectations, as predetermined by the organization, are liable for a portion (up to 100%) of cost overruns.~~

~~*Two-sided risk sharing*~~ ***Factor 3:* Shared savings with downside risk**

Payers and providers agree upon a set budget and quality performance thresholds. Providers are accountable for part or all healthcare costs if they cannot keep costs lower than the set benchmarks.

***Factor 4*: ~~*Capitation*~~/Population-based payment**

Payments are not tied to delivery of services, but take the form of a fixed per patient, per unit of time sum paid in advance to the provider/practitioner for delivery of a set of services (partial capitation) or all services (full or global capitation). The provider/practitioner assumes partial or full risk for costs above the capitation/ population-based payment amount and retains all (or most) savings if costs fall below the capitation/population-based payment amount. Payments, penalties and awards depend on quality of care.

***Factor 5:* Overall rate of payments tied to alternative payment models**
~~**Calculating VBP reach**~~

Percentage of payments is calculated by:

- Numerator: Value-based payments, *divided by*
- Denominator: All payments (including FFS).

The percentage of payments reflects 12 months of payments within the look-back period, and can be based on allowed amounts, actual payments or forecasted payments.

Types of providers/practitioners

For each type of VBP arrangement, the organization reports a percentage of total payments, and indicates the provider/practitioner types included in the arrangement.

Exceptions

None.

Examples **Calculating APM reach**

The denominator is 12 months of all payments, but if there are 3 months of APMs in the look-back period, the numerator is the 3 months of APMs.

Element D: Alternative Payment Model Growth

The organization annually demonstrates an increase in total percentage of payments tied to alternative payment models.

Scoring

Met	Partially Met	Not Met
The organization meets the requirement	No scoring option	The organization does not meet the requirement

Data source Reports

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

NCQA reviews and scores this element for each product line brought forward for Accreditation. A value of 1% or more meets this requirement.

Documentation

For First Surveys and Renewal Surveys: NCQA overall rate increase or decrease provided by the organization.

Look-back period *For First Surveys and Renewal Surveys:* At least once during the prior 12 months.

Explanation This element may not be delegated.

Exceptions

None.

Examples None.

PHM 6: Population Health Management Impact

The organization measures the effectiveness of its PHM strategy.

Intent

The organization has a systematic process to evaluate whether it has achieved its goals and to gain insights into areas needing improvement.

Element B: Improvement and Action

The organization uses results from the PHM impact analysis to annually:

1. **Identify <u>at least two opportunities</u> for improvement.**
2. **Act on ~~one~~ <u>at least two opportunities</u> for improvement.**

Scoring

Met	Partially Met	Not Met
The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review

Product lines

This element applies to Renewal Surveys for all product lines.

NCQA reviews and scores this element for each product line brought forward for Accreditation.

Documentation

NCQA reviews the organization's most recent and previous annual comprehensive analysis of PHM strategy impact.

For factor 2, NCQA reviews a documented process, reports or materials, depending on the action taken to address identified opportunities.

Look-back period

For Renewal Surveys: 24 months.

Explanation

This element is a **structural requirement.** The organization must present its own documentation.

***Factor 1:* Opportunities for improvement**

The organization uses the results of its analysis to identify <u>at least two</u> opportunities for improvement, which may be different each time data are measured and analyzed. ~~NCQA does not prescribe a specific number of improvement opportunities.~~

***Factor 2:* Act <u>two</u> on opportuni<u>ties</u> for improvement**

The organization acts on at least one <u>two</u> identified opportuni<u>ties</u> for improvement.

Exceptions

None.

Examples None.

Proposed Network Management Updates

NET 1: Availability of Practitioners

The organization maintains sufficient numbers and types of primary care, behavioral health and specialty care practitioners in its network.

Intent

The organization maintains an adequate network of primary care, behavioral healthcare and specialty care practitioners (SCP) and monitors how effectively this network meets the needs and preferences of its membership.

Element A: Cultural Needs and Preferences

The organization annually:
1. Assesses the cultural, ethnic, racial and linguistic needs of its members.
2. Adjusts the availability of practitioners within its network, if necessary.

Summary of changes

- ~~No changes to this element~~.

Scoring

Met	Partially Met	Not Met
The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews the organization's data collection methodology (presented as a documented process or within the report), assessment of unmet member needs and characteristics of the practitioner network and documentation of any adjustments made in the network to meet identified needs annually.

For First Surveys: NCQA reviews the organization's most recent report.

For Renewal Surveys: NCQA reviews the organization's most recent and previous year's reports.

Look-back period

For First Surveys: At least once during the prior year.

For Renewal Surveys: 24 months.

Explanation

***Factor 1:* Assessing members' needs**

Data collection. To assess the cultural, ethnic, racial and linguistic needs of its members relative to its network, the organization must first collect data on cultural, ethnic, racial and linguistic characteristics of its members. Additional characteristics include veteran/military status, age (child/adolescent/older adult), urban/rural geography and/or disability status.

A separate source of data specific to cultural characteristics (e.g., employer demographics, member surveys or focus groups) is not required.

Assessment. The organization assesses the unmet needs of its members relative to its network. To meet the factor, the organization must address all four needs separately.

Cultural preferences and beliefs may be assessed from members (e.g., member surveys or focus groups) or other sources. If using other sources, aspects of culture can be initially inferred from ethnic, racial and linguistic characteristics but must also be supplemented with information about the cultural needs and preferences (e.g., religion, family traditions, customs) of its population or populations with similar characteristics. The organization may use existing health services research.

Factor 2: **Practitioner availability**

In order to determine if member needs are met by the network or if adjustments are needed to meet member needs, the organization assesses the characteristics (culture, ethnicity, race, spoken language) of network practitioners. The assessment is not intended to compare practitioner and member demographics.

The organization adjusts the practitioner network to provide the types and number of practitioners necessary to meet the cultural, ethnic, racial and linguistic needs of its members within defined geographical areas. Adjustment of the practitioner network may include requiring existing practitioners to complete cultural competency training, providing practitioners with culturally and linguistically appropriate health education materials, or recruiting practitioners whose cultural and ethnic backgrounds are similar to the underrepresented member population. The organization determines appropriate adjustments based on identified needs.

The organization receives credit for factor 2 if it demonstrates that it is not necessary to adjust the practitioner network, based on its assessment of members' unmet needs and applicable characteristics of the network.

Exceptions

None.

Examples

Five-step process for meeting the intent of this element

1. Collect data on ethnic, racial and linguistic needs of members from U.S. Census and enrollment data.
2. Conduct research or review literature on cultural needs and preferences based on the characteristics of the organization’s members.
3. Correlate data with members' preferences based on member feedback or complaint data.
4. Assess the cultural, ethnic, racial and linguistic characteristics of network practitioners to evaluate whether network practitioners meet members’ needs.
5. Take action to adjust the practitioner network if it does not meet members’ cultural, ethnic, racial and linguistic needs.

Data sources

- Data from survey questions or focus groups that identify the health-related preferences or beliefs of specific ethnic groups.
- U.S. Census data on the racial/ethnic composition of the population within a service area or region.
- Practitioner race, ethnicity and language data collected during the credentialing process.
- Published health statistics, health services research, data provided by plan sponsors or government agencies.

Actions resulting from assessment

- Recruit, credential and contract with practitioners who speak a language that reflects members' linguistic needs.
- Recruit, credential and contract with practitioners whose cultural and ethnic backgrounds are similar to the underrepresented member population.
- Require practitioners to complete cultural competency training courses based on the racial/ethnic composition of the member population.

Element D: ~~Practitioners Providing Behavioral Healthcare Ensuring~~ Availability and Accessibility in Behavioral Health

To evaluate the availability of high-volume behavioral healthcare practitioners in its delivery system, the organization:

1. **Defines the types of high-volume behavioral healthcare practitioners.**
2. **Establishes measurable standards for the number of each type of high-volume behavioral healthcare practitioner.**
3. **Establishes measurable standards for the geographic distribution of each type of high-volume behavioral healthcare practitioner.**
4. **Analyzes performance against the standards annually.**

Summary of changes

- ~~No changes to this element.~~

Scoring

Met	Partially Met	Not Met
The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data source Documented process, Reports

Scope of review

Product lines

This element applies to First Survey and Renewal Surveys for all product lines.

Documentation

NCQA reviews policies and procedures in place throughout the look-back period for factors 1–3.

For First Surveys: NCQA also reviews the organization's most recent annual analysis report for factor 4.

For Renewal Surveys: NCQA also reviews the most recent and the previous year's annual analysis reports for factor 4.

Look-back period

For First Surveys: At least once during the prior year.

For Renewal Surveys: 24 months.

Explanation

Factors 1–3 are **structural requirements**. The organization must present its own documentation.

The organization's standards for behavioral healthcare practitioner availability are realistic for the community and the delivery system, and consider clinical safety.

Factor 1: **Types of behavioral healthcare practitioners**

~~The organization's policies and procedures explain how it defines high-volume behavioral healthcare practitioners. The organization defines the types of behavioral healthcare practitioners across the continuum of care.~~The organization defines all types of behavioral healthcare practitioners and providers—not only high-volume practitioners—in its delivery system across the continuum of care, including:

- Psychiatrists.
- Clinical psychologists.
- Psychiatric nurse practitioners.
- Licensed professional counselors.
- Social workers.
- Peer support specialists.
- Inpatient, residential and ambulatory provider organizations.

Factor 2: **Standards for number of behavioral healthcare practitioners**

The organization expresses the standard for number of behavioral healthcare practitioners in the following ways: ~~one of the following ways:~~

- The ratio of each type of behavioral healthcare practitioner to the number of members.
- The percentage of practitioners who submitted in-network claims for a specific number of unique members.
- The ratio of each type of behavioral healthcare practitioner accepting new patients to the number of members.

Factor 3: **Standards for geographic distribution of behavioral healthcare practitioners**

The organization expresses the standard for geographic distribution of behavioral healthcare practitioners in two of four ways ~~one of two ways:~~

- Acceptable distance to a behavioral healthcare practitioner's office from the member's home.
- Acceptable driving time to a behavioral healthcare practitioner's office from the member's home.

- Proximity of practitioner or provider site to public transportation.
- Availability for telehealth practitioners or providers.

Factor 4: **Quantitative and qualitative analysis**

For initial measurement, the organization conducts quantitative and qualitative analysis of data.

For remeasurement, the organization conducts quantitative analysis, and conducts qualitative analysis if quantitative analysis demonstrates that stated goals were not met.

To analyze its performance against the availability standards from factors 2–3, the organization collects data using measures that allow direct comparison against standards defined in the factors.

The analyses are refined enough to identify access concerns in subpopulations, specific products/product lines or geographic areas.

Refer to *Appendix 4: Glossary* for the full definition of and requirements for *quantitative analysis* and *qualitative analysis*.

Exception

This element is NA if all purchasers of the organization's services carve out or exclude behavioral healthcare.

Examples

Common types of behavioral healthcare practitioners

- Psychiatrist.
- Addiction medicine specialist.
- Clinical psychologist.
- Clinical social worker.
- Psychiatric clinical nurse specialist.
- Substance abuse counselor.
- Marriage and family therapist.
- Psychiatric nurse practitioners.

Identifying high-volume behavioral healthcare practitioners

- Identify practitioners located in an expected high-volume geographic area or in high-volume disciplines, or both.
- Use available prior-encounter data.
- Identify certain types of practitioners most likely to provide services to the largest segment of the membership; for example, social workers might see more members for treatment than psychiatrists.

Table 1: Ratio of behavioral healthcare practitioner types to members (factor 2)

Practitioner Type	Measure	Standard and Performance Goal
Psychiatrist	Psychiatrists to members	1:2,000
Clinical psychologist	Clinical psychologists to members	1:15,000
Licensed clinical social worker	Licensed clinical social workers to members	1:10,000
Marriage and family counselor	Marriage and family counselors to members	1:3,000

Table 2: Number and geographic distribution of behavioral healthcare practitioners, miles (factors 2, 3)

Practitioner Type	Standard	Performance Goal
Psychiatrist	One within 10 miles of member's home	95%
Clinical psychologist	One within 20 miles of member's home	95%
Licensed clinical social worker	One within 10 miles of member's home	95%
Marriage and family counselor	One within 10 miles of member's home	95%

Table 3: Number and geographic distribution of behavioral healthcare practitioners, driving time (factors 2, 3)

Practitioner Type	Standard	Performance Goal
Psychiatrist	One within 15 minutes driving time of member's home	95%
Clinical psychologist	One within 25 minutes driving time of member's home	95%
Licensed clinical social worker	One within 25 minutes driving time of member's home	95%

Marriage and family counselor	One within 15 minutes driving time of member's home	95%

NET 2: Accessibility of Services

Element B: Access to Behavioral Healthcare

Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for behavioral healthcare for:

1. **Care for an emergency crisis.**
2. **Non-life-threatening emergency within 6 hours. ***
3. ~~2~~**Urgent care within 48 hours.***
4. ~~3~~**Initial visit for routine care within 10 business days.**
5. **Follow-up routine care.**

Critical factors: Score cannot exceed Partially Met if one critical factor is scored "no." Score cannot exceed Not Met if two or more critical factors are scored "no."

Summary of changes

- ~~No changes to this element.~~

Scoring

Met	Partially Met	Not Met
The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data source Documented process, Reports, Materials

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

For First Surveys: NCQA reviews the organization's most recent annual data collection and analysis report for all factors.

For Renewal Surveys: NCQA reviews the organization's most recent and the previous year's annual data collection and analysis reports.

For factor 1 for all surveys: If the organization directs members with non-life-threatening emergencies to the emergency department (ED), NCQA reviews the organization's report, policies or other documentation.

For each factor, the organization separates prescribes and non-prescribers.

For ~~the care for a non-life threatening emergency component of~~ factor 1, if the organization directs members in crisis or with non-life threatening emergencies to the 988 Suicide and Crisis Lifeline, behavioral health urgent care, ED (hospital or psychiatric) or mobile crisis response teams, NCQA reviews the organization's report, policies or other documentation.

Look-back period

For First Surveys: At least once during the prior year.

For Renewal Surveys: 24 months.

Explanation

This is a **structural requirement**. The organization must present its own documentation.

Factors 1 and 2 are critical factors; if one critical factor is scored "No" the organization's score cannot exceed "Partially Met" for the element. If both critical factors are scored "No," the organization's score cannot exceed "Not Met" for the element.

Data collection methods

The organization determines its data collection methodology. The data collection methodology allows identification of issues at the organizational level.

The organization may collect data across the entire practitioner or member population or from a statistically valid sample. If the organization collects data using surveys or practitioner self-reported information, it supplements the data with an analysis of complaints regarding behavioral healthcare access. Supplemental complaint data are used to validate survey findings and self-reported information and assists in qualitative analysis of the primary data. The organization is not required to conduct a complete quantitative and qualitative analysis on supplemental data.

Data collection, quantitative and qualitative analyses

To analyze its performance against the access standards from factors 1–5~~4~~, the organization collects data using measures that allow direct comparison against standards it defines.

For initial measurement, the organization conducts quantitative and qualitative analysis of data.

For remeasurement, the organization conducts quantitative analysis, and conducts qualitative analysis if quantitative analysis demonstrates that stated goals were not met.

Analyses may be conducted at the organizational level (practitioners and practices may be grouped together). If analyses reveal issues, the organization conducts a practitioner-level analysis (by individual behavioral healthcare practitioner) across all behavioral healthcare practitioners and practices, or from a statistically valid sample, to determine if members are able to get an appointment.

The analyses are refined enough to identify access concerns in subpopulations, specific products/product lines or geographic areas.

Refer to *Appendix 4: Glossary* for the full definition of and requirements for *quantitative analysis* and *qualitative analysis*.

***Factors 1–5~~4~~:* Access to behavioral healthcare and appointments**

Directing members to the ED. The organization meets the "non-life-threatening emergencies" component of factor 1 if it directs members to the ED or behavioral health crisis units. The organization incorporates 988 Suicide and Crisis Lifeline into its response to members in crisis or with non-life threatening emergencies. The organization emphasizes the use of crisis intervention teams, behavioral health urgent care, psychiatric EDs and mobile response teams.

The organization's report includes separate analyses of appointment availability for behavioral healthcare practitioners who prescribe medications (e.g., psychiatrists) and for behavioral healthcare practitioners who do not prescribe medications (e.g., psychologists) for each factor. This includes the percentage of appointments scheduled within the time frames in factors 1–5.

***Factor 4~~3~~:* Initial routine care**

Initial routine care appointments do not include follow-up care for an existing problem.

***Factor 5~~4~~:* Follow-up routine care appointments**

Follow-up routine care appointments are visits at specified dates to evaluate patient progress and other changes that have taken place since a previous visit.

Exception

This element is NA if all purchasers of the organization's services carve out or exclude behavioral healthcare.

Examples

***Factor 1:* Care for a non-life-threatening emergency within 6 hours**

- Report showing that all members who contacted the organization for a non-life-threatening emergency were directed to the crisis intervention resources or ED instead of being scheduled for a doctor's visit.
- Customer Service telephone script that instructs staff to direct members with non-life-threatening emergencies to the crisis intervention resources ~~ED~~ or behavioral health crisis unit.

***Factor 4:* Follow-up of routine care**

Setting timeliness standards (step 1)

1. 90% of sites have slots for routine follow-up appointments with prescribers within 30 days and with nonprescribers within 20 days.
2. 75% of members have a follow-up visit with a prescriber within 30 days of an initial visit for a specific condition and with a nonprescriber within 20 days of an initial visit for a specific condition.
3. 90% of members report that they "always" or "usually" get a follow-up appointment with a prescriber, and 90% of members report that they "always" or "usually" get a follow-up appointment with a nonprescriber.

Data sources to assess reasonable access (step 2)

1. Site surveys indicate:

- 80% of sites reported having slots for routine follow-up appointments with prescribers within 30 days.
- 85% of sites reported having slots for routine follow-up appointments with nonprescribers within 20 days.

2. Claims data analysis indicates:

- 50% of members had routine follow-up appointments with a prescriber within 30 days of an initial visit for a specific condition.
- 60% of members had routine follow-up appointments with nonprescribers within 20 days of initial visit for a specific condition.

3. Complaint data analysis indicates:

- 70% of members reported that they "always" or "usually" get a follow-up appointment with a prescriber.
- 80% of members reported that they "always" or "usually" get a follow-up appointment with a nonprescriber.

Element D: Assessment Against Accommodation Standards for Behavioral Healthcare

The organization evaluates whether appointment availability (operating hours, scheduling, and other practices) align with member needs by:

1. **Collecting data about members' ability to schedule appointments during standard working hours, evenings and weekends.**
2. **Analyzing the data.**

Summary of Changes

- This is a new element.

	Met	Partially Met	Not Met
Scoring	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Reports

Scope of review *For Initial Surveys:* NCQA reviews the organization's most recent annual data collection and analysis report for all factors.
For Renewal Surveys: NCQA reviews the organization's most recent and previous year's annual data collection and analysis reports for all factors.
For each factor, the organization separates prescribers and non-prescribers.

Look-back period *For Initial Surveys:* At least once during the prior year.
For Renewal Surveys: 24 months.

Explanation **THIS IS A CORE ELEMENT.** The organization must meet this requirement even if it does not have any clients or serve as a delegate.
This element is a structural requirement. The organization must present its own documentation.

Factor 1: **Appointment Availability**

Data collection methods. The organization determines its data collection methodology. The methodology allows identification of issues at the organizational level.

The organization may collect data across the entire practitioner or member population, or from a statistically valid sample. If the organization collects data using surveys or practitioner self-reported information, it supplements the data with an analysis of complaints regarding behavioral healthcare access. Supplemental complaint data are used to validate survey findings and self-reported information, and assist in qualitative analysis of the primary data. The organization is not required to conduct a complete quantitative and qualitative analysis of supplemental data.

The organization's report includes separate analyses of scheduling options for behavioral healthcare practitioners who prescribe medications (e.g., psychiatrists) and for behavioral healthcare practitioners who do not prescribe medications (e.g., psychologists).

Standard working hours: 8am to 6pm. Initial routine care appointments do not include follow-up care for an existing problem.

Evening: After 4pm.

Weekends: Friday evening, Saturday and Sunday.

Factor 2: **Analysis**

Data collection, quantitative and qualitative analyses. To analyze its performance against the access standard from factor 1, the organization collects data using measures that allow direct comparison against standards it defines.

For initial measurement, the organization conducts quantitative and qualitative analysis of data.

For remeasurement, the organization conducts quantitative analysis, and conducts qualitative analysis if quantitative analysis demonstrates that the stated goals were not met.

Analyses may be conducted at the organizational level (behavioral healthcare practitioners and practices may be grouped together). If analyses reveal issues, the organization conducts a practitioner-level analysis (by individual behavioral healthcare practitioner) across all behavioral healthcare practitioners and practices, or from a statistically valid sample, to determine if members are able to get an appointment.

The analyses are refined enough to identify access concerns in subpopulations, specific products/product lines or geographic areas.

Refer to the glossary appendix for the full definition of and requirements for quantitative analysis and qualitative analysis.

Examples **Data collection and analysis**

- Analysis of member complaints by ~~accessibility~~ accommodation standards.

- Member surveys that ask questions directly related to the ~~accessibility~~ accommodation standards, supplemented with an analysis of member complaints.
- Practice-specific surveys regarding ~~access~~ scheduling flexibility ~~to practitioners' offices~~, supplemented with an analysis of member complaints and other relevant satisfaction data.

NET 3: Assessment of Network Adequacy

Element C: Opportunities to Improve Access to Behavioral Healthcare Services

The organization annually:

1. **Prioritizes opportunities for improvement identified from analyses of availability (NET 1, Elements A and D), accessibility (NET 2, Element B) and member experience accessing the network (NET 3, Element A, factors 2 and 4), and accommodation standards (NET 2, Element D).**
2. **Implements interventions on at least one opportunity, if applicable.**
3. **Measures the effectiveness of the interventions, if applicable.**

Summary of changes

- No changes to this element.

Scoring

Met	Partially Met	Not Met
The organization meets 3 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data source Documented process, Reports, Materials

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product lines may be combined.

Documentation

For First Surveys: NCQA reviews the organization's most recent report.

For Renewal Surveys: NCQA reviews the organization's most recent and previous year's reports.

For factor 2 for both survey types: NCQA reviews a documented process, reports or materials, depending on the action taken to address identified opportunities.

Look-back period

For First Surveys: At least once during the prior year.

For Renewal Surveys: 24 months.

Explanation

Factor 1

The organization summarizes opportunities identified from analysis of behavioral healthcare data to show a comprehensive overview of network access issues. Data may be reported individually, but must be evaluated collectively in a single, comprehensive analysis to meet this element. The organization prioritizes opportunities by importance to member need and risk to member access to behavioral healthcare services.

Factor 2: **Implementing interventions**

No additional explanation required.

Factor 3: **Measuring effectiveness**

The organization must measure the effectiveness of its actions each year. The organization may measure the same issue for both years or select a new issue for the second year.

Exceptions

This element is NA if all purchasers of the organization's services carve out or exclude behavioral healthcare.

Factor 3 is NA for First Surveys.

Factors 2 and 3 are NA if the organization's assessment does not identify opportunities for improvement. NCQA evaluates whether this conclusion is reasonable, given assessment results.

Examples None.

NET 5: Physician and Hospital Directories

The organization provides information to help members and prospective members choose physicians and hospitals.

Intent

The organization's directories offer information to members and prospective members that is useful in selecting a physician and hospital.

Element A: Physician Directory Data

The organization has a web-based physician directory that includes search capabilities for the following physician information:

1. Name.

2. Gender.

3. Specialty.
4. Hospital affiliations.
5. Medical group affiliations.
6. Board certification.
7. Accepting new patients.
8. Languages spoken by the physician or clinical staff.
9. Office locations and phone numbers.

Summary of changes

- ~~No changes to this element.~~

Scoring

Met	Partially Met	Not Met
The organization meets ~~8~~-9 factors	The organization meets 6-8 ~~5-7~~ factors	The organization meets 0-5~~4~~ factors

Data source Materials

Scope of review

Product lines

For First Surveys, this element applies to all product lines.

For Renewal Surveys, this element applies to the Medicaid product line only.

Documentation

NCQA reviews the organization's web-based directory or screenshots of the website that is in place throughout the look-back period.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

This requirement applies only to network physicians.

Every field must be populated. If a factor does not apply to a physician, the data field indicates "None" or "NA."

The directory must include all physicians who fall under the scope of credentialing defined in CR 1, Element A, with the following exceptions:

- Rental network physicians who are exclusively for out-of-area care.
- Behavioral healthcare physicians in a delegated MBHO, if the organization directs members to the MBHO but not to specific physicians.

The directory:

- Allows customized searches based on the information most relevant for members, ***or***
- Allows searches by field or by ZIP code and specialty, and contains:

- An advanced-search option using multiple variables required in factors 1–8.
- Instructions on using the advanced-search function, and a direct link to the function.

Factors 1, 2

No additional explanation required.

Factor 3: **Specialty**

The directory lists:

- All applicable specialties, for physicians.
  - ~~The directory is not required to list subspecialty~~. For behavioral health practitioners, the directory lists a practitioner subspecialty, area of expertise or focus.
- All applicable disciplines, for contracted behavioral healthcare physicians.

Factor 4: **Hospital affiliations**

The directory lists hospitals in the organization's network where physicians have admitting or attending privileges.

Factor 5: **Medical group affiliations**

The directory lists medical groups in the organization's network with which the physicians are affiliated.

Factor 6: **Board certification**

The directory lists physicians' board certification from ABMS or AOA, ***and*** either:

- A link directly to ABMS or AOA to verify current status, ***or***
- Instructions for checking the most current board certification status on the ABMS or AOA website.

Factor 7: **Accepting new patients**

The directory indicates whether physicians who practice in the following areas are accepting new patients:

- General or family medicine.
- Internal medicine.
- Pediatrics.
- Obstetrics/gynecology.
- High-volume behavioral healthcare.

Factor 8: **Languages spoken by the physician or clinical staff**

The directory may list languages spoken by the nonclinical staff in a separate field.

The organization is not required to include English in the list of spoken languages.

Factor 9: **Office location and phone numbers**

The directory lists the physical addresses and phone numbers of office locations where physicians practice. If a physician sees patients only virtually, the directory must indicate "virtual-only" in lieu of a physical office location.

The directory also states if a practitioner provides telehealth and in-person appointments.

Exception

This element is NA for Renewal Surveys for the commercial, Medicare and Exchange product lines.

Examples None.

Element C: Assessment of Physician Directory Accuracy

Using valid methodology, the organization performs an ~~annual~~ evaluation at least every 6 months of its physician directories for:

1. **Accuracy of office locations and phone numbers.**
2. **Accuracy of hospital affiliations.**
3. **Accuracy of accepting new patients.**
4. **Awareness of physician office staff of physician's participation in the organization's networks.**

Summary of changes

- ~~No changes to this element.~~

Scoring

Met	Partially Met	Not Met
The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data source Reports

Scope of review

Product lines

This element applies to First Surveys and *Renewal Surveys for all product lines*.

Documentation

For First Surveys: NCQA reviews the organization's most recent annual report.

For Renewal Surveys: NCQA reviews the organization's most recent and the previous year's annual reports.

Look-back period

For First Surveys: At least once with the past 6 months. ~~once during the prior year.~~

For Renewal Surveys: 24 months.

Explanation

***Factors 1–3:* Measurement and analysis of accuracy**

The organization describes its methodology and provides the accuracy rate for each factor.

The organization uses valid methodology to collect data on whether the information listed in its physician directories for factors 1–4 is correct. The organization may include its entire physician network in its measurement or draw statistically valid samples. If the organization uses a sample, it describes the sample universe and the sampling methodology.

The organization may use data from surveys, practitioner self-reported information or member complaints regarding the accuracy of physician directories. If the organization collects information from surveys, its methodology description includes the process for physician outreach if its response rates are low.

The organization is not required to conduct a quantitative analysis, but must conduct a qualitative analysis to examine the underlying reasons for results.

Refer to *Appendix 4: Glossary* for the full definition of and requirements for *qualitative analysis*.

***Factor 4:* Awareness of physician participation in the organization's networks**

The organization provides members with accurate information on in-network physicians to avoid barriers to access. The organization determines if there is a lack of awareness on the part of physician office staff or if the organization has incorrectly listed a physician as in-network.

The organization assesses that network physician office staff can identify every product/product line and organization network in which the physician participates.

Exception

Factor 4 is NA for an integrated HMO model (all practitioners and office staff are employees of the organization).

Examples

The organization conducted an analysis of information frequently found to be out of date in its physician directories. It drew a single, representative sample of primary care practitioners and specialists across all of its networks using a 95% confidence level and a 5% confidence interval (margin of error).

For factors 1–3, the organization conducted a two-phase mailing to validate the accuracy of the data. The organization compared the survey responses with the information listed in the web directory within 30 calendar days of receiving a response, to minimize the chance that differences were due to real changes in physician information over time. If the provider's survey response matched the information published in its web directory, the information was considered accurate.

For factor 4, the organization conducted telephone surveys on practices selected in the sample and compared its directory information to information in its physician contracts.

Factor 1: **Office location/phone numbers**

Numerator: Number of respondents with correct addresses/phone numbers listed in the directory.

Denominator: Total number of physician offices sampled.

Office Location/ Phone Numbers	**Primary Care Practitioners**		**Specialists**	
	Commercial	**Medicaid**	**Commercial**	**Medicaid**
Numerator	90	75	40	31
Denominator	120	87	45	36
Rate	75%	86%	89%	86%

Factor 2: **Hospital affiliations**

Numerator: Number of respondents whose hospital affiliations are correctly listed in the directory.

Denominator: Number of physicians in the sample.

Hospital Affiliations	**Primary Care Practitioners**		**Specialists**	
	Commercial	**Medicaid**	**Commercial**	**Medicaid**
Numerator	111	82	39	30
Denominator	120	87	45	36
Rate	93%	94%	87%	83%

Factor 3: **Accepting new patients**

Numerator: Number of respondents correctly listed in the directory as accepting new patients.

Denominator: Number of physician offices in the sample.

Accepting New Patients	Primary Care Practitioners		Specialists	
	Commercial	Medicaid	Commercial	Medicaid
Numerator	97	82	42	34
Denominator	120	87	45	36
Rate	81%	94%	93%	94%

Factor 4: **Current network participation**

Numerator: Number of respondents who correctly identified the networks in which they participate and the directory matched its contracts.

Denominator: Number of physician offices in the sample.

Active Network Contracts	Primary Care Practitioners		Specialists	
	Commercial	Medicaid	Commercial	Medicaid
Numerator	100	76	42	33
Denominator	120	87	45	36
Rate	83%	87%	93%	92%

Element F: Hospital Directory Data

The organization has a web-based hospital directory that includes search capabilities for the following information:

1. Hospital name.
2. Hospital location and phone number.
3. Hospital accreditation status.
4. Hospital quality data from recognized sources.

Summary of changes

~~**Corrections**~~

- ~~Removed "Quality Check" from the factor 4 examples.~~

Scoring

Met	Partially Met	Not Met
The organization meets ~~3~~-4 factors	The organization meets 2-3 factors	The organization meets 0-1 factors

Data source Materials

Scope of review **Product lines**

For First Surveys, this element applies to all product lines.

For Renewal Surveys, this element applies to the Medicaid product line only.

Documentation

NCQA reviews the organization's web-based directory or screenshots of its web-based directory that is in place throughout the look-back period.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

This requirement applies only to network hospitals.

Every field must be populated. If information is not available, the data field indicates "None" or "NA."

A hospital is an institution that primarily provides diagnostic and therapeutic services to patients admitted for medical diagnosis, treatment and care of injured, disabled, or ill individuals by or under the supervision of a physician.

This element is includes acute care hospitals and specialty acute care such as children's hospitals, ~~or~~ Veteran Affairs and behavioral health hospitals.

The hospital directory:

- Allows searches by ZIP code.
- Allows customized searches.
- Has clear instructions for finding hospitals using searchable fields.

Factor 1: **Hospital name**

No additional explanation required.

Factor 2: **Hospital location**

The directory lists the physical addresses and phone numbers of primary and affiliated locations.

Factor 3: **Hospital accreditation status**

The directory indicates whether the hospital is accredited, the accrediting body and the accreditation status by one of the following methods:

- Lists hospital accreditation status and the accrediting body, ***or***
- Provides a link to the accrediting body's web page that displays the hospital's accreditation status.
    - A link to the general website does not meet factor 3.

Factor 4: **Hospital quality data from recognized sources**

The hospital directory contains quality data from recognized national or state sources, or contains a link (if it exists) to a recognized source for quality data specific to each hospital. If there are limitations (e.g., a requirement to accept terms of agreement) to linking to the data, a link to the quality data landing page is acceptable. A link to the source's general website home page is not acceptable.

Exception

This element is NA for Renewal Surveys for the commercial, Medicare and Exchange product lines.

Related information

The organization is not required to include rental network hospitals in the directory if it does not contract with the hospitals in the network.

Examples

Factor 4: **Nationally recognized hospital quality sources**

- Care Compare.
- The Leapfrog Group.

Element I: Usability Testing

The organization evaluates its web-based physician and hospital directories for understandability and usefulness to members and prospective members at least every 3 years, and considers the following:
1. Reading level.
2. Intuitive content organization.
3. Ease of navigation.
4. Directories in additional languages, if applicable to the membership.

Summary of changes

Clarifications

- Revised the third paragraph in the explanation to clarify that internal staff must reflect the population that will use the directories.

Scoring

Met	Partially Met	Not Met
The organization meets ~~3~~-4 factors	The organization meets 2-3 factors	The organization meets 0-1 factors

Data source Documented process, Reports

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews the organization's policies and procedures in place throughout the look-back period and evidence that it conducted usability testing.

Look-back period

For First Surveys and Renewal Surveys: At least once in the prior 36 months.

Explanation

The organization conducts usability testing:

- When there are significant changes to member demographics.
- When there are changes to the layout or design of the directory.

The audience for the usability testing reflects the population that will use the directories.

The organization is not required to conduct usability testing with an external audience. Testing with internal staff who were not involved in development of the physician and hospital directories meets the intent if staff reflect the population that will use the directories.

Factors 1–4: **Usability testing**

No additional explanation required.

Exception

Factor 4 is NA if the membership does not warrant directories in additional languages.

Related information

Information on usability testing. For additional information on usability testing, refer to https://digital.gov.

Use of vendors for usability testing services. If the organization contracts with a vendor to provide usability testing services, it provides access to the vendor's documentation. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under NET 6. NCQA evaluates the vendor's documentation against the requirements. Refer to *Vendors* in Appendix 2.

Examples

None.

Proposed Utilization Management Updates

Utilization Management Standards

UM 1: Program Structure

The organization's UM program has clearly defined structures and ~~processes, and~~ assigns responsibility to appropriate individuals.

Intent

The organization has a well-structured UM program and makes utilization decisions affecting the health care of members ~~in a~~ fair<u>ly</u>, impartial<u>ly</u> and consistent<u>ly.</u> ~~manner~~

Element A: ~~Written~~ Program Description

The organization's <u>written</u> UM program description includes<u>:</u> ~~the following:~~

1. **A ~~written~~ description of the program structure.**
2. **The behavioral healthcare aspects of the program.**
3. **Involvement of a designated senior-level physician in UM program implementation.**
4. **Involvement of a designated behavioral healthcare practitioner in the implementation of the behavioral healthcare aspects of the UM program.**
5. **<u>Oversight of UM functions by a UM Committee.</u>**
6. **<u>A process for determining requests that require prior authorization.</u>**
7. **~~5.~~ The program scope and process used to determine benefit coverage and medical necessity.**
8. **~~6.~~ Information sources used to determine benefit coverage and medical necessity.**

Scoring

Met	Partially Met	Not Met
The organization meets 7-8 factors	The organization meets 5-6 factors	The organization meets 0-4 factors

Data source Documented process, ~~Reports~~

Scope of review

Product lines

For Interim Surveys and First Surveys, this element applies to all product lines.

For Renewal Surveys, this element applies to the Medicaid product line only.

Documentation

For Interim Surveys: NCQA reviews the organization's <u>written</u> UM program description.

For First Surveys and Renewal Surveys: NCQA reviews the organization's <u>written</u> UM program description.

~~*For factors 3 and 4,* NCQA also reviews three UM Committee meeting minutes *or* other reports documenting active involvement of a senior-level physician and a designated behavioral healthcare practitioner in the UM program throughout the look-back period, or reviews all UM committee meeting minutes or other reports if the organization has fewer than three.~~

Look-back period

For Interim Surveys: Prior to the survey date.

For Initial Surveys: 6 months.

For Renewal Surveys: 24 months for factors 1–4 and 7–8; prior to the survey date for factors 5–6.

Explanation

This element is a **structural requirement.** The organization must present its own documentation.

The UM program description is organized and written so that staff members and others can understand the program's structure, scope, processes and information sources used to make UM determinations.

Medical necessity review

Medical necessity review is a process to consider whether services that are covered only when medically necessary meet criteria for medical necessity and clinical appropriateness. A medical necessity review requires consideration of the member's circumstances, relative to appropriate clinical criteria and the organization's policies.

NCQA's UM standards specify the steps in the medical necessity review. Medical necessity review requires that denial decisions be made only by an appropriate clinical professional as specified in NCQA standards.

Decisions about the following require medical necessity review:

- Any covered medical benefits defined by the organization's Certificate of Coverage or Summary of Benefits, including, but not limited to:
  - Dental and vision services covered under medical benefits, including dental care or services associated with procedures that occur within or adjacent to the oral cavity or sinuses.
    - If medical and dental benefits are not differentiated in the benefits plan, the organization includes requests for care or services associated with dental procedures that occur within or adjacent to the oral cavity or sinuses for medical necessity review.
  - *Specialty dental and vision plans only:* All dental and vision services covered under the benefits plan.
  - Pharmaceuticals covered under medical or pharmacy benefits.
- Preexisting conditions, when the organization has a policy to deny coverage for care or services related to preexisting conditions.
- Care or services whose coverage depends on specific circumstances.
- Out-of-network services that are only covered in clinically appropriate situations.
- Prior authorizations for pharmaceuticals and pharmaceutical requests requiring prerequisite drug for a step therapy program.
- "Experimental" or "investigational" requests covered by the organization.

Decisions about the following do not require medical necessity review:

- Services in the member's benefits plan that are limited by number, duration or frequency.
- Extension of treatments beyond the specific limitations and restrictions imposed by the member's benefits plan.
- Care or services whose coverage does not depend on any circumstances.
- Requests for personal care services, such as cooking, grooming, transportation, cleaning and assistance with other activities of daily living.
- "Experimental" or "investigational" requests that are always excluded and are never covered under any circumstances. In these instances, the organization either:
    - Identifies the specific service or procedure excluded from the benefits plan, ***or***
    - If benefits plan materials include broad statements about exclusions but do not specify excluded services or procedures, the materials state that members have the opportunity to request information on excluded services or procedures and that the organization maintains internal policies or criteria for these services or procedures.

If the services above, which do not require medical necessity review, are denied and subsequently appealed, they are within the scope of *UM 8: Policies for Appeals* and *UM 9: Appropriate Handling of Appeals*.

Dental and vision services not covered under a member's medical benefits are not within the scope of denial and appeal file review.

For specialty dental and vision plans only: All dental and vision services covered under a dental or vision benefits plan are within the scope of denial and appeal file review.

NCQA does not have any additional classifications of denials, such as administrative.

Medical necessity review of requests for out-of-network coverage

Requests for coverage of out-of-network services that are only covered when medically necessary or in clinically appropriate situations require medical necessity review. Such requests indicate the member has a specific clinical need that the requestor believes cannot be met in-network (e.g., a service or procedure not provided in-network; delivery of services closer or sooner than provided or allowed by the organization's access or availability standards).

If the certificate of coverage or summary of benefits specifies that the organization never covers an out-of-network service for any reason or if the request does not indicate the member has a specific clinical need for which out-of-network coverage may be warranted, the request does not require medical necessity review.

Denials ~~s~~ ~~F~~file review universe (UM 4-UM 7)

Although medical necessity review may result in approvals or denials, NCQA reviews only denials resulting from medical necessity review, as defined above, in UM 4–UM 7.

If an organization only makes medical necessity recommendations to its clients and not medical necessity decisions, NCQA reviews the recommendation-only files against the requirements in UM 4–UM 7.

The UM medical necessity denial file-review universe is in three categories:

1. *Behavioral healthcare.* Includes denials of requests for evaluation or treatment of mental health conditions and psychological and substance abuse disorders.
2. *Pharmacy.* Includes denials of requests for pharmaceuticals covered under medical or pharmacy benefits and administered or dispensed in all settings (e.g., inpatient, outpatient, at the pharmacy, at home) does not include:
    - Denials of requests for medical devices (e.g., insulin pumps and other types of DME).
    - Denials of requests for formulary exceptions (refer to UM 11, Element E).
3. *Nonbehavioral healthcare.* Includes denials of requests for coverage of medical, dental, vision or other nonbehavioral healthcare and nonpharmaceutical services, including, but not limited to, medical devices.

NCQA reviews denials, whether or not the member is at financial risk, excluding postservice payment disputes initiated by a practitioner or provider where the member is not at financial risk.

Members are considered to be at financial risk when:

- They have financial liability (i.e., co-insurance, deductibles, charges in excess of allowed amounts, differentials in cost between in-network care and out-of-network care, costs that vary within the formulary) for services beyond a flat copay that is always the same fixed dollar amount.
    - Copays may vary across a range of services, but must not be different within the same service category (e.g., $15 for primary care office visits and $25 for specialist office visits is acceptable), ***or***
- They may be balance-billed by a practitioner, provider or other party.

Classification of overturned denials. Although federal regulations may define an overturned denial based on the discussion between the member's treating practitioner and another physician or other appropriate reviewer (as described in UM 7~~: Denial Notices~~*)* as an appeal, such an approval does not fall under the scope of NCQA's appeal standards. The case is considered a denial if a denial notice was issued.

Appeal file-review universe (UM 9)

The member or their authorized representative may formally request an appeal of a previous decision (e.g., denials resulting from medical necessity review; benefit payment denial; rescission or reduction of coverage or provision of care; administrative action or quality-of-care or service issue). NCQA evaluates upheld appeals of an adverse decision for coverage of care or services under UM 9.

NCQA does not divide the UM appeal file-review universe into separate categories. The file-review universe includes all appeals for coverage of health care services for nonbehavioral healthcare, behavioral healthcare and pharmacy in one file universe, unless an exception in UM 9 applies.

Organization employees and their dependents: The organization may exclude employees and their dependents from the denial and appeal file universe.

***Factor 1:* Description of ~~P~~program structure**

The ~~written~~ UM program description includes all of the following information about the ~~UM~~ program structure:

- UM staff~~'s~~ assigned activities.
- UM staff ~~who have~~with the authority to deny coverage.
  - Involvement of a designated physician and a designated behavioral healthcare practitioner.
- The process for evaluating, approving and revising the UM program, and the staff responsible for each step.
- The UM program's role in the QI program, including how the organization collects UM information and uses it for QI activities.
- The organization's process for handling appeals and making appeal determinations.

Staff size. NCQA does not prescribe staff size or a method or criteria for determining staff size.

***Factor 2:* Behavioral healthcare aspects of the program**

The program description specifies how the organization addresses sites of behavioral healthcare services (e.g., psychology groups) and levels of behavioral healthcare services (e.g., inpatient psychiatric care, outpatient psychiatrist visits). If the organization has a process for triage and referral to behavioral health services, the program description specifies the process.

***Factor 3:* Senior-level physician involvement**

The program description specifies how a senior-level physician (a medical director, associate medical director or equivalent) is actively involved in the organization's UM Committee, UM activities, including implementation, supervision, oversight and evaluation of the UM program.

For specialty organizations: If the organization only provides UM for services not provided by physicians (e.g., dental care), a senior-level practitioner who represents the organization's specialty (e.g., a DDS) may substitute.

Factor 4: **Designated behavioral healthcare practitioner involvement**

The program description specifies how a designated behavioral healthcare physician or a doctoral-level behavioral healthcare practitioner is actively involved in the organization's UM Committee, implementing and evaluating the behavioral health aspects of the UM program.

The behavioral healthcare practitioner must be a physician or have a clinical PhD or PsyD, and may be a medical director, clinical director, a participating practitioner from the organization or a behavioral healthcare delegate (if applicable).

NEW Factor 5: **Oversight of UM functions by UM Committee**

The organization describes committee oversight of its UM functions. The organization may use any standing committee, such as a UM committee or its QI committee. At a minimum, the committee includes participation of the senior-level physician (factor 3) and the designated behavioral healthcare practitioner (factor 4), as applicable.

The UM Committee:

- Annually reviews the UM program structure, scope, processes, process updates and information sources used to determine benefit coverage and medical necessity.
- Evaluates the findings from UM data analyses, including:
  - Overall approval rates.
  - The percentage of services requiring prior authorization that have an approval rate of 90% or more.
  - Overall denial rates.
  - Overturned appeal rate.
  - Turnaround timeframe compliance rate.
  - Denial rate by reason category.
  - Appeal upheld rate by reason category.
- Makes recommendations for improving the effectiveness of the UM program and rates.
- Evaluates the overall effectiveness of the UM program.

NEW Factor 6: **Process for determining requests that require prior authorization**

The program description describes the organization's process for determining requests that require prior authorization, and for removing prior authorization requirements for requests.

Factors ~~5~~7, ~~6~~8: **Processes and information sources used to make determinations**

The program description specifies:

- The organization's UM functions, the services covered by each function or protocol and the criteria used to determine medical necessity, including:
  - How the organization develops and selects criteria.
  - How the organization reviews, updates and modifies criteria.
- How medical necessity and benefits coverage for inpatient and outpatient services are determined.
- The description of the data and information the organization uses to make determinations (e.g., patient records, conversations with appropriate physicians) and guide the UM decision-making process.
  - The description should not be burdensome for the member, the practitioner or the health delivery organization's staff.
- The triage and referral process for behavioral healthcare services (if applicable).
- How sites of service and levels of care are evaluated for behavioral healthcare services (if applicable).

The program description lists the information (e.g., patient records, conversations with appropriate physicians) the organization uses to make UM determinations.

Exceptions

This element is NA for Renewal Surveys for the commercial, Medicare and Exchange product lines.

Factors 2, 4 and behavioral healthcare aspects of factor 5 are NA if all purchasers of the organization's services carve out or exclude behavioral healthcare.

Related information

Benefits plan exceptions. If the organization makes an exception to authorize a service, grants an extension of benefits or makes an exception to a limitation in the benefits plan (e.g., the organization covers up to 20 therapy visits but allows 21 visits), a subsequent denial of the same service or a request for an extension or exception is not considered a medical necessity determination.

Examples

Factor 3: **Senior-level physician involvement**

The senior-level physician's responsibilities may include, but are not limited to:

- Setting UM policies.
- Supervising program operations.
- Reviewing UM cases.
- Participating on the UM Committee.

- Evaluating the overall effectiveness of the UM program.

Factor 4: **Behavioral healthcare practitioner involvement**

The designated behavioral healthcare practitioner's responsibilities may include, but are not limited to:

- Setting UM behavioral healthcare policies.
- Reviewing UM behavioral healthcare cases.
- Participating on the UM Committee.

NEW Element B: UM Data Collection

The organization annually reports:

1. **The overall approval rate.**
2. **The percentage of services requiring prior authorization that have an approval rate of 90% or more.**
3. **The overall denial rate.**
4. **Denial rates by reason.**
5. **The overall appeal rate.**
6. **The appeal overturn rate.**
7. **Timeliness of notification rate.**

Summary of changes

- This is a new element.

Met	Partially Met	Not Met
The organization meets 7 factors	No scoring option	The organization meets 0-6 factors

Data source Reports

Scope of review

Product lines

This element applies to all product lines for First Surveys and Renewal Surveys

Documentation

NCQA reviews the organization's completed UM report in IRT. The element applies to the organization’s data and to all delegate data. Organizations earn credit for this element by completing the self-reported table in IRT.

NCQA reviews and scores this element separately for each product line brought forward for Accreditation.

Look-back period

For All Surveys: At least once during the prior year.

Explanation

The intent of this element is not to compare rates across organizations or product lines.

This element applies to urgent concurrent, urgent preservice and nonurgent preservice requests, and to preservice and expedited appeals.

Factors 1–6 do not apply to postservice requests and postservice appeals.

Factor 7 applies to urgent concurrent, urgent preservice, nonurgent preservice and postservice requests.

The organization calculates its UM rates according to the formulas in each factor. This element is not limited to medical necessity determinations. Partial denials count as denials. If any part of a request is approved, the organization may count it as part of the approval rate calculation.

***Factor 1:* Overall approval rate**

The overall approval rate measures the proportion of prior authorization requests that were granted approval out of the total number of UM decisions made within a given reporting period.

The organization calculates the following according to the formula below:

- Overall approval rate = (Total number of approval decisions/Total number of UM decisions)*100.
    - Total number of approval decisions: Includes all UM requests that received an approval decision.
    - Total number of UM decisions: Includes all UM requests reviewed, encompassing both approvals and denials, excluding pending.

***Factor 2:* Percentage of services that require prior authorization**

To determine whether services and procedures are subject to prior authorization, the organization compiles a list of all nonbehavioral and behavioral services and procedures subject to prior authorization into a report, and evaluates one of the following:

- Services or procedures that are approved 90% or more:
    - At the procedural level (e.g., spinal surgery).
    - At the individual code level within a procedure.
    - Across all codes subject to prior authorization.

***Factor 3*: Overall denial rate**

The overall denial rate measures the proportion of UM decisions that result in a denial rather than an approval.

The organization calculates the following according to the formula below:

- Overall denial rate = (Total number of denial decisions/Total number of UM decisions)*100.
  - Total number of denial decisions: Includes all UM requests that received a denial decision.
  - Total number of UM decisions: Includes all UM requests reviewed, encompassing both approvals and denials, excluding pending.

Factor 4: **Denial rates by reasons**

The organization calculates its rate for each of the following reasons for denials and upheld appeals:

Lack of medical necessity rate =	(Total number of denial or upheld appeal decisions due to lack of medical necessity / Total number of denial or upheld appeal decisions) *100
Insufficient information rate =	(Total number of denial or upheld appeal decisions due to insufficient information / Total number of denial or upheld appeal decisions) *100
Out-of-network provider rate =	(Total number of denial or upheld appeal decisions due to an out of network provider / Total number of denial or upheld appeal decisions) *100
Benefit exclusion or limitation rate =	(Total number of denial or upheld appeal decisions due to benefit exclusions / Total number of denial or upheld appeal decisions) *100

Factor 5: **Overall appeal rate**

The overall appeal rate is a metric used to evaluate how frequently denied UM requests are appealed, this provides insight into the volume of appeals and whether initial denial decisions align with coverage and medical necessity standards.

The organization calculates the overall appeal rate according to the formula below:

- Overall appeal rate = (Total number of appeal requests/total number of denial decisions) *100.
  - Total number of appeal requests: The total count of UM denials that were appealed during the reporting period.
  - Total number of denial decisions: The total count of UM requests that were denied, regardless of reason, during the reporting period.

Factor 6: **Appeal overturn rate**

The internal and external appeal overturn rate measures the proportion of denied UM decisions that were reversed through the appeal process, either through the internal or external reviews.

The organization calculates its internal and external appeal overturn rate according to the formula below:

- Internal appeal overturned rate = (Total number of internal overturned decisions/Total number of internal appeal decisions) *100.
    - Total number of internal overturned decisions: The count of denials that were overturned during internal appeals process.
    - Total number of internal appeal decisions: The total number of appeals completed in the internal review process, whether upheld or overturned.
- External appeal overturned rate = (Total number of external overturned decisions/Total number of external appeal decisions) *100.
    - Total number of external overturned decisions: The count of denials that were overturned during external review process.
    - Total number of external appeal decisions: The total number of appeals reviewed in the external review process, whether upheld or overturned.

Factor 7: **Timeliness of notification rates**

This factor applies to all UM denial determinations. The organization applies the decision notification time frames in UM 5.

The organization calculates the rates of adherence to the time frames for each category of request:

- Urgent concurrent.
- Urgent preservice.
- Nonurgent preservice.
- Post-service.

For each category, the organization uses the following formula:

- (Total number of requests meeting the notification time frame/The total number of all requests) *100.

The organization's notification time frame begins on receipt of the request and ends when the decision is sent to the member and treating practitioner.

Note: *For organizations that do not communicate with members and practitioners, the notification time frame begins from the receipt of the request and ends when the decision or recommendation is sent to the client.*

Exceptions

None.

NEW Element C: Analysis of UM Data Collection

The organization annually performs analysis of the data from Element B.

Summary of changes

- This is a new element.

Met	Partially Met	Not Met
The organization meets the requirement	No scoring option	The organization does not meet the requirement

Data source Reports

Scope of review

Product lines

This element applies to all product lines for First Surveys and Renewal Surveys

Documentation

NCQA reviews the organization's UM analysis reports completed during the look-back period.

NCQA reviews and scores this element separately for each product line brought forward for Accreditation.

Look-back period

For All Surveys: At least once during the prior year.

Explanation

The organization uses the data it reported in Element B to complete a quantitative and qualitative analysis.

Quantitative and qualitative analysis

The organization conducts a quantitative analysis of the results and a qualitative analysis of results that do not meet performance goals.

Refer to the glossary appendix for the full definition of and requirements for *quantitative analysis*.

Exceptions

None.

NEW Element D: UM Committee

The organization's UM Committee annually:

1. Evaluates the UM program.
2. Identifies actions to address findings in factor 1.
3. Identifies actions to address the analysis of UM rates in Element C.

Summary of changes

- This is a new element.

Scoring

Met	Partially Met	Not Met
The organization meets 3 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data source Materials, Reports

Scope of review

Product lines

This element applies to all product lines for First Surveys and Renewal Surveys

Documentation

For All Surveys: NCQA reviews the organization's most recent committee meeting minutes; reports documenting active involvement of a senior-level physician and a designated behavioral healthcare practitioner; and evidence that the organization provided the analysis report from Element C to its UM Committee.

NCQA reviews and scores this element separately for each product line brought forward for Accreditation.

Look-back period *For All Surveys:* At least once during the prior year.

Explanation The organization describes committee oversight of its UM functions. The organization may use any standing committee, such as a UM committee or its QI committee or another committee. The organization demonstrates active involvement of the senior-level physician (Element A, factor 3) and the designated behavioral healthcare practitioner (Element A, factor 4), as applicable, and provides evidence that it submitted its analysis report from Element C to the UM Committee.

Annual meetings and decisions may take place through video conference or web conference with audio, but may not be conducted only through email.

***Factor 1:* UM program**

The committee evaluates the organization's UM program to determine if it remains current and appropriate, including:

- The program structure.
- The program scope, processes and information sources used to determine benefit coverage and medical necessity.
- UM criteria.
- The process for determining requests that require prior authorization (Element A, factor 6).
- The overall effectiveness of the UM program.

Factor 2: **Identify needed action to improve the UM program**

The committee identifies actions to improve the organization's UM program based on the evaluation of factor 1, prioritizes them based on their significance and recommends actions for the organization to pursue.

Factor 3**: Identify action to address analysis of UM rates**

The committee identifies actions to address the root causes of the organization's UM rates that do not meet performance goals, based on the evaluation in Element C, prioritizes them based on their significance and recommends actions for the organization to pursue.

Exceptions

None.

NEW Element E: Implementation of Improvement Actions

The organization annually implements interventions based on recommendations from the UM Committee (Element D) to:
1. Improve effectiveness of the UM program.
2. Address root causes of low or high UM rates.

Summary of changes

- This is a new element.

Scoring

Met	Partially Met	Not Met
The organization meets 2 factors	The organization meets 1 factors	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review **Product lines**

This element applies to all product lines for First Surveys and Renewal Surveys

Documentation

NCQA reviews the documentation of actions the organization planned to take, or has taken, to address UM Committee recommendations.

NCQA reviews and scores this element separately for each product line brought forward for Accreditation.

Look-back period

For All Surveys: At least once during the prior year.

Explanation

This element is a structural requirement. The organization must present its own documentation.

Factors 1, 2

The organization documents actions taken or planned, including dates of actions, to address UM Committee recommendations to improve the effectiveness of the UM program and address the root causes of low or high UM rates. One action may address more than one finding, if appropriate. The organization identifies staff (by title) who are responsible for implementing actions. The organization considers member and practitioner experience data when making updates to improve the overall effectiveness of the UM program.

Exceptions

None.

NEW Element F: Measurement of the Effectiveness of Interventions

After the interventions in Element E have been implemented, the organization:
1. Evaluates improvement of UM program effectiveness.
2. Evaluates improvement of UM rates.
3. Reports the findings of factors 1 and 2 to the UM Committee.

Summary of changes

- This is a new element.

Scoring

Met	Partially Met	Not Met
The organization meets 3 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data source Materials, Reports

Scope of review

Product lines

This element applies to all product lines for First Surveys and Renewal Surveys

Documentation

For All Surveys: NCQA reviews the organization's most recent evaluation of effectiveness. NCQA reviews minutes of meetings when the organization reported audit results to its UM Committee.

NCQA reviews and scores this element separately for each product line brought forward for Accreditation.

For all surveys scheduled on or between July 1, 2026, and June 30, 2027, the organization may submit a detailed implementation plan, including a timeline, instead of reports or materials.

Look-back period *For All Surveys:* At least once during the prior year.

Explanation **This element is a structural requirement.** The organization must present its own documentation.

***Factors 1–2:* Measure of effectiveness**

The organization evaluates the effectiveness of interventions in Element E within 3–6 months of implementing them to determine improvement in the UM program and UM rates, and draws conclusions about the overall effectiveness of implementations. The organization conducts a qualitative analysis if it identifies no improvement.

***Factor 3:* Report findings to the UM Committee**

The organization reports findings from factors 1 and 2 at the next scheduled UM Committee meeting.

For all surveys scheduled on or between July 1, 2026, and June 30, 2027, the organization may complete an implementation plan in place of reports or materials. The plan must include:

- A timeline for evaluating the effectiveness of interventions implemented to improve the UM program and rates.
- A timeline for reporting the findings to the UM committee.

- A description outlining roles and responsibilities.

UM 2: Clinical Criteria for UM Decisions

The organization uses written criteria based on sound clinical evidence to make utilization decisions, and specifies procedures for appropriately applying the criteria.

Intent

The organization applies objective and evidence-based criteria, and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services.

Element A: UM Criteria

The organization:

1. **Has written UM decision-making criteria that are objective and based on medical evidence.**
2. **Has written policies for applying the criteria based on individual needs.**
3. **Has written policies for applying the criteria based on an assessment of the local delivery system.**
4. **Involves appropriate practitioners in developing, adopting and reviewing criteria.**
5. **Annually reviews the UM criteria and the procedures for applying them, and updates the criteria when appropriate.**

Scoring

Met	Partially Met	Not Met
The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 0-2 factors

Data source Documented process, Reports, Materials

Scope of review

Product lines

This element applies to all product lines for Interim Surveys, First Surveys and Renewal Surveys.

Documentation

For Interim Surveys: NCQA reviews the organization's policies and procedures for factors 1–5.

For First Surveys and Renewal Surveys: NCQA reviews:

- *For factors 1–3:* The organization's policies and procedures in place throughout the look-back period. If the organization only uses its clients' criteria and does not have its own criteria, NCQA reviews the organization's policies and procedures for using and applying its clients' criteria.
- *For factor 4:* Three examples of meeting minutes or reports documenting the involvement of appropriate practitioners throughout the look-back period, or all UM committee meeting minutes or reports if the organization has fewer than three.

- *For factor 5:* The most recent annual review and update (for *Initial Surveys*) or most recent and previous year's annual reviews and updates (for *Renewal Surveys*).

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months for factors 1–4; at least once during the prior year for factor 5.

For Renewal Surveys: 24 months.

Explanation

This element is a **structural requirement.** The organization must present its own documentation.

***Factor 1:* Written UM decision-making criteria**

The organization has specific criteria to determine the medical necessity and clinical appropriateness of medical, behavioral healthcare and pharmaceutical services requiring approval. The organization may address factors 2 and 3 as part of the UM criteria, or in separate, overriding documented processes for staff (e.g., standing instructions for staff to use when determining whether UM guidelines are appropriate for a specific situation).

***Factor 2:* Consideration of individual needs**

The organization considers at least the following characteristics when applying criteria to each individual:

- Age.
- Comorbidities.
- Complications.
- Progress of treatment.
- Psychosocial situation.
- Home environment, when applicable.

***Factor 3:* Assessment of the local delivery system**

The organization's UM policies and procedures require consideration of available services in the local delivery system and their ability to meet the member's specific health care needs, when UM criteria are applied.

***Factor 4:* Practitioner involvement**

Practitioners with clinical expertise in the area being reviewed <u>are provided</u> ~~have~~ the opportunity to advise or comment on development or adoption of UM criteria and on instructions for applying criteria. Although the organization may use practitioners that are its staff, non-staff network practitioners must also be involved in developing, adopting and reviewing criteria, because they are subject to application of the criteria. If an organization has been unable to involve network practitioners, it must document its attempts and provide the documentation to NCQA during the survey.

The organization may have practitioners review criteria if it does not develop its own UM criteria, and obtains criteria from external entities.

If an organization does not have its own practitioner network, it must involve the UM Committee. ~~use an advisory committee or staff practitioners~~.

Factor 5: **Reviewing and updating criteria**

The organization reviews its UM criteria and procedures against current clinical and medical evidence, and updates them~~,~~ when appropriate. If new scientific evidence is not available, the UM Committee ~~a designated group~~ may determine if further review of a criterion is necessary.

Exceptions

Factor 5 is NA for UM criteria in use for less than 12 months.

Related information

Factors 2, 3: Applying criteria. Nationally developed procedures for applying criteria, particularly those for length of hospital stay, are often designed for "uncomplicated" patients and for a comprehensive delivery system; they may not be appropriate for patients with complications or for a delivery system with insufficient alternatives to inpatient care. Written UM procedures direct decision makers to alternative procedures or approaches (e.g., a secondary set of UM criteria and individual case discussions) when assessment indicates that UM guidelines are not appropriate.

Examples

Factor 3: **Assessment of the local delivery system**

Assessment of available services in the local delivery system and their ability to meet a member's health care needs could include:

- Availability of inpatient, outpatient and transitional facilities.
- Availability of outpatient services in lieu of inpatient services (e.g., ~~such as~~ surgery centers vs. inpatient surgery).
- Availability of highly specialized services~~,~~ such as transplant facilities or cancer centers.
- Availability of skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the patient after hospital discharge.
- Local hospitals' ability to provide all recommended services within the estimated length of stay.

Factor 4: **Practitioner involvement**

The organization solicits opinions about the UM criteria through either of the following:

- Practitioner participation on a committee.
- Distributing the UM criteria to applicable practitioners.

In large regional or national organizations, a central office may develop or adopt criteria if practitioners with clinical expertise are involved in their development or adoption.

Element B: Availability of UM Criteria

The organization makes UM criteria available to practitioners at the point of care.
~~**1. States in writing how practitioners can obtain UM criteria.**~~
~~**2. Makes the criteria available to its practitioners upon request.**~~

Scoring

Met	Partially Met	Not Met
The organization meets the requirement	No scoring option	The organization does not meet the requirement

Data source Documented process, Reports, Materials

Scope of review

Product lines

This element applies to all product lines for Interim Surveys and First Surveys.

Documentation

For Interim Surveys: NCQA reviews the organization's documented process for making criteria available.

For *First and Renewal Surveys* NCQA reviews the organization's communication of criteria availability to each practitioner at least once during the look-back period. ~~and that the criteria were made available upon request throughout the look-back period~~

Look-back period

For All Surveys: Prior to the survey date.

~~*For Initial Surveys:* 24 months for factor 1 and 6 months for factor 2.~~

~~*For Renewal Surveys:* 24 months~~.

Explanation The organization distributes criteria by mail, fax or email, or on its website, if it informs practitioners that the information is available online. The organization mails the criteria to practitioners who do not have fax, email or internet access upon request.

~~***Factor 1:* How to obtain criteria**~~

~~No additional explanation required.~~

~~***Factor 2:* Availability of the UM criteria upon request**~~

The organization makes criteria available at the point of care~~upon request~~, through any ~~of the~~ distribution method~~s~~ listed above or through ~~either~~ any of the following methods:

- ~~In person, at the organization.~~
- ~~By telephone.~~
- Through the EHR.
- On its website.
- By telephone.

If the organization does not have a practitioner network and is not delegated to communicate to client practitioners regarding criteria availability, then annual notification is not required. The organization posts on its public website that criteria are available. ~~upon request.~~

Exceptions

~~Factor 2 is NA if the organization demonstrates that it informed practitioners of the UM criteria's availability upon request, but no practitioners requested the criteria.~~

Examples None.

Element C: Consistency in Applying Criteria

At least annually, the organization:

1. **Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making.**
2. **Acts on opportunities to improve consistency, if applicable.**

Scoring

Met	Partially Met	Not Met
The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review

Product lines

This element applies to all product lines for First Surveys and Renewal Surveys.

Documentation

NCQA reviews evaluation results or similar documentation, and evidence (e.g., minutes, policies, procedural updates) that the organization acted on opportunities.

Look-back period *For First Surveys:* At least once during the prior year.

For Renewal Surveys: 24 months.

Explanation The evaluation of interrater reliability applies only to determinations made as part of a UM process.

Factor 1: **Evaluation of consistency**

The organization evaluates the consistency with which physician and nonphysician reviewers apply UM criteria:

- Using hypothetical UM test cases, ***or***
- Using a sample of UM determination files.
  - If the organization uses a sample of UM determination files, it uses one of the following auditing methods:
    - 5% or 50 ~~of its~~ UM determination files, whichever is fewer, ***or***
    - NCQA "8/30 methodology" available at http://www.ncqa.org/programs/accreditation/policy-updates-supporting-documents, ***or***
    - Another statistically valid method.

Factor 2: **Acting on opportunities**

No additional explanation required.

Exceptions

Factor 2 is NA if the organization has no opportunities to improve consistency. NCQA evaluates whether this conclusion is reasonable, given evaluation results.

Examples None.

UM 3: Communication Services

The organization provides access to staff for members and practitioners seeking information about the UM process and the authorization of care.

Intent

Members and practitioners can access staff to discuss UM issues.

Element A: Access to Staff

The organization provides the following communication services for members and practitioners:

1. **Staff are available at least 8 hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues.**
2. **Staff can receive inbound communication regarding UM issues after normal business hours.**
3. **Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues.**

4. **TDD/TTY services for members who need them.**
5. **Language assistance for members to discuss UM issues.**
6. **Member navigation assistance with denials, appeals or UM questions.**

Scoring

Met	Partially Met	Not Met
The organization meets 5-6 factors	The organization meets 3-4 factors	The organization meets 0-2 factors

Data source Documented process, Materials

Scope of review

Product lines

This element applies to all product lines for Interim Surveys, First Surveys and Renewal Surveys.

Documentation

For factors 1–3: NCQA reviews the organization's policies and procedures for providing communication services to members and practitioners that are in place throughout the look-back period.

For factors 4–6: ~~, 5~~: NCQA reviews materials or other evidence that demonstrate services provided to members at least once during the look-back period.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 24 months for factors 1–5; prior to the survey date for factor 6.

Explanation Member Services staff may triage communications to UM staff.

The organization is not required to offer TDD/TTY (factor 4) and language services (factor 5) to practitioners.

***Factor 1:* Communication during business hours**

No additional explanation required.

***Factor 2:* Communication after business hours**

The organization uses any of the following methods for after-hours communication, as appropriate:

- Telephone.
- Email.

- Fax.
- Electronic portal.

Communications received after normal business hours are returned on the next business day, and communications received after midnight on Monday–Friday are responded to on the same business day.

Factor 3: **Staff identification**

The organization's policies and procedures state that when organization staff initiate or return calls to members or practitioners regarding UM issues, they identify themselves by name, title and organization.

Factor 4: **TDD/TTY services**

TDD (telecommunications device for the deaf) or TTY (telephone typewriter, or teletypewriter) are electronic devices for text communication via a telephone line, used when one or more parties have hearing or speech difficulties. The organization provides a separate phone number for receiving TDD/TTY messages, or uses the State/711 Relay Services.

Factor 5: **Language assistance**

~~For all members who request language services, t~~The organization provides free language services~~, free of charge,~~ to all members who request them, ~~in the requested language~~ through bilingual staff or an interpreter.

Use of contracted translation services is not considered delegation.

This factor does not apply to after-hours communications.

NEW Factor 6: **Member navigation assistance**

The organization provides assistance to members to help them understand UM decisions. The organization may refer members to staff or to resources that can help them interpret UM decisions.

Exception

None.

Examples

Factors 4, 5: **TDD/TYY services and language assistance**

- Dated contracts.
- Dated call scripts.
- Notifications (e.g., newsletters, member letters) sent to members indicating TDD/TTY and language assistance services are available.

NEW Factor 6: **Member navigation assistance**

- A member calls and requests help understanding their UM decision. Staff provide information to resolve their questions.

UM 5: Timeliness of UM Decisions

The organization makes UM decisions in a timely manner to accommodate the clinical urgency of the situation.

Intent

The organization makes UM decisions in a timely manner to minimize any disruption in the provision of health care.

Element A: Notification of Nonbehavioral Healthcare Decisions

The organization adheres to the following time frames for notification of non-behavioral healthcare UM decisions:

1. **For urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.**
2. **For urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.**
3. **For ~~commercial and Exchange~~ nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within ~~15~~ 7 calendar days of the request.**
4. ~~**For Medicare and Medicaid nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 14 calendar days of the request.**~~
4. **For postservice decisions, the organization gives electronic or written notification of the**
5. ~~**decision to members and practitioners within 30 calendar days of the request.**~~

Scoring

Met	Partially Met	Not Met
High (90-100%) on file review	Medium (60-89%) on file review	Low (0-59%) on file review

Data source Records or files

Scope of review

Product lines

This element applies to all product lines for First Surveys and Renewal Surveys.

NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product line files may be combined.

Documentation

For First Surveys and Renewal Surveys: NCQA reviews a random sample of up to 40 nonbehavioral healthcare denial files resulting from medical necessity review for evidence of timeliness of notification.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

THIS IS A MUST-PASS ELEMENT.

This element applies to all nonbehavioral healthcare denial determinations resulting from medical necessity review (as defined in *UM 1: Program Structure,* Element A).

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Definitions used when classifying UM requests

Urgent request: A request for medical care or services where application of the time frame for making routine or non-life threatening care determinations:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, ***or***
- Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, ***or***
- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

Concurrent request: A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.

Nonurgent request: A request for medical care or services for which application of the time periods for making a decision does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Preservice request: A request for coverage of medical care or services that the organization must approve in advance, in whole or in part.

Postservice request: A request for coverage of medical care or services that have been received (e.g., retrospective review).

Reclassification of nonbehavioral requests that do not meet the definition of "urgent." All types of requests received while the member is receiving care may be reclassified as preservice or postservice if the request does not meet the definition of "urgent." This includes a request to extend a course of treatment beyond the time period or number of treatments previously approved by the organization. The request may be handled as a new request and decided within the time frame appropriate for the type of decision notification (i.e., preservice or postservice).

Factors 1–4 ~~5~~: **Timeliness of notification**

NCQA considers 24 hours to be equivalent to 1 calendar day and 72 hours to be equivalent to 3 calendar days.

NCQA measures timeliness of notification from the date when the organization receives the request from the member or the member's authorized representative, even if the organization does not have all the information necessary to make a decision, to the date when the notice was provided to the member and the attending or treating practitioner, as applicable.

The organization notifies the member (or their authorized representative) and the member's attending or treating practitioner of the UM decision within the time frames specified in factors 1–4.

For urgent concurrent decisions, the organization may notify the provider (e.g., hospital, rehabilitation facility, DME, home health) or Utilization Review department staff, with the understanding that staff will inform the attending or treating practitioner.

The organization may address the notification to the attention of the attending or treating practitioner under certain circumstances. Refer to *Related information.*

The organization documents the date when it receives the request, and the date of the decision notification, in the UM file. The request is received when it arrives at the organization, even if it is not received by the UM department.

For organizations that do not communicate with members and practitioners, NCQA measures timeliness from when the request is received from the client.

For Medicare urgent requests only: NCQA measures timeliness of notification for urgent requests from the date when the appropriate department receives the request. The organization documents the date when the appropriate department receives the request, and the date of the decision notification, in the UM file.

If the organization sends written notice, NCQA uses the date on the notice as the notification date. If the organization does not retain copies of the written notice, it has other methods of documenting the notification date. If the organization uses electronic notification, NCQA uses the date when the notification was posted in the electronic system.

The organization may extend the decision notification time frame under certain circumstances. Refer to *Related information.*

Exceptions

Exceptions to member notification. NCQA does not require the organization to notify a member of:

- An urgent concurrent denial.
- An urgent preservice denial.
- A postservice (retrospective) denial if the member is not at financial risk.

For urgent denials, NCQA considers the attending or treating practitioner to be acting as the member's representative. During the file review process, NCQA assesses whether the decision notification time frames to the practitioner were appropriate.

This element is NA if the organization performs only UM pharmacy activities for clients.

Factor 3 is NA for the Medicare and Medicaid product lines.

Factor 4 is NA for the commercial and Exchange product lines.

Related information

An organization may have procedures for ongoing review of urgent concurrent care that was approved initially. For ongoing review, the notification period begins on the day of the review. The organization documents the date of the review and the decision notification in the UM denial file.

Addressing notices to the attention of the attending or treating practitioner. For preservice and postservice decisions, if attending or treating practitioner information ~~on the attending or treating practitioner~~ was not provided with the request, or if the request was from a provider (e.g., facility)~~,~~ and not ~~rather than~~ from a practitioner, the organization makes at least two attempts to identify the practitioner, and documents its attempts in the UM file. Leaving a voicemail counts as one attempt. If the organization cannot identify the attending or treating practitioner, it addresses the notification "to the attention of the attending or treating practitioner" (in this case, the attending or treating practitioner's name is not required).

For urgent concurrent decisions, the organization may inform the provider's Utilization Review department staff without attempting to identify the attending or treating practitioner.

~~For urgent concurrent decisions, the organization may inform the hospital Utilization Review (UR) department staff without attempting to identify the treating practitioner, with the understanding that staff will inform the attending/treating practitioner.~~

~~In all cases, if the practitioner is not known, the organization must address the notification to the attention of the attending or treating practitioner; the practitioner name is not required.~~

Receiving requests after normal business hours. Due to the nature of urgent requests, the organization has procedures for accepting them after normal business

hours. NCQA counts the time from the date when the organization receives the request, whether or not it is during business hours.

Postservice payment disputes. Postservice requests for payment initiated by a practitioner or a facility are not subject to review if the practitioner or facility has no recourse against the member for payment (i.e., the member is not at financial risk). Exclude denials of such requests from the file review universe.

Approving alternative services. If the organization approves an alternative to the service being requested and the member or the member's authorized representative does not request or agree to the alternative service, the organization would be denying care that was originally requested; therefore, this is considered a denial and should be included in the file review universe. However, if the member or the member's authorized representative agrees to the alternative and the care is authorized, the member or the member's authorized representative has essentially withdrawn the initial request; therefore, this is not considered a denial and should not be included in the file review universe.

Extending time frames. Members or their authorized representatives may agree to extend the time frame for urgent, preservice and postservice requests.

Extension conditions

Factors 1, 2: Urgent concurrent and urgent preservice requests for Medicare and Medicaid product lines.

For Medicare, the organization may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, ***or***
- The organization needs additional information, ***and***
    - Documents that it made at least one attempt to obtain the necessary information.
    - Notifies the member or the member's authorized representative of the delay.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

For Medicaid, the organization may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, ***or***
- The organization needs additional information, provided it documents that it made at least one attempt to obtain the necessary information.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

Factors 1, 2: Urgent concurrent and urgent preservice requests for commercial and Exchange product lines.

For commercial and Exchange, extensions are not allowed for urgent concurrent decisions.

For urgent preservice, the organization may extend the time frame once due to lack of information, for 48 hours, under the following conditions:

- Within 24 hours of receipt of the urgent preservice request, the organization asks the member or the member's representative for the information necessary to make the decision, ***and***
- The organization gives the member or the member's authorized representative at least 48 hours to provide the information, ***and***
- The extension period, within which a decision must be made by the organization, begins on the sooner of:
    - The date when the organization receives the member's response (even if not all of the information is provided), ***or***
    - The last date of the time period given to the member to provide the information, even if no response is received from the member or the member's authorized representative.

Factor 3: Nonurgent preservice requests for commercial and Exchange product lines. If the request lacks clinical information, the organization may extend the nonurgent preservice time frame for up to 15 calendar days, under the following conditions:

- Before the end of the time frame the organization asks the member or the member's representative for the information necessary to make the decision, ***and***
- The organization gives the member or the member's authorized representative at least 45 calendar days to provide the information.
- The extension period, within which a decision must be made by the organization, begins on the sooner of:
    - The date when the organization receives the member's response (even if not all of the information is provided), ***or***
    - The last date of the time period given to the member to supply the information, even if no response is received from the member or the member's authorized representative.

The organization may deny the request if it does not receive the information within the time frame, and the member may appeal the denial.

Factor 3 4: Nonurgent preservice requests for Medicare and Medicaid product lines.

For Medicare, the organization may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, ***or***
- The organization needs additional information, ***and***
    - Documents that it made at least one attempt to obtain the necessary information.

- Notifies the member or the member's authorized representative of the delay.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

For Medicaid, the organization may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, ***or***
- The organization needs additional information, provided it documents that it made at least one attempt to obtain the necessary information.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.
Factor 4 ~~5~~: Postservice requests for commercial, Exchange and Medicaid product lines. If the request lacks clinical information, the organization may extend the postservice time frame for up to 15 calendar days, under the following conditions:

- Before the end of the time frame, the organization asks the member or the member's representative for the information necessary to make the decision, ***and***
- The organization gives the member or the member's authorized representative at least 45 calendar days to provide the information.
- The extension period, within which a decision must be made by the organization, begins on the sooner of:
  - The date when the organization receives the member's response (even if not all of the information is provided), ***or***
  - The last date of the time period given to the member to supply the information, even if no response is received from the member or the member's authorized representative.

The organization may deny the request if it does not receive the information within the time frame, and the member may appeal the denial.
Extension for other reasons. In a situation beyond the organization's control (e.g., waiting for an evaluation by a specialist), it may extend the nonurgent preservice and postservice time frames once, for up to 15 calendar days, under the following conditions:

- Within 15 calendar days of a nonurgent preservice request, the organization notifies the member (or the member's authorized representative) of the need for an extension and the expected date of the decision.
- Within 30 calendar days of a postservice request, the organization notifies the member (or the member's authorized representative) of the need for an extension and the expected date of the decision.

For Medicare, extensions are not allowed for postservice requests.
Factors 1, 2: Verbal notification of denials. Verbal notification does not replace electronic or written notification of denial decisions, but when provided, the

organization may extend the time frame for electronic or written notification for commercial, Medicare and Exchange decisions as described below.

- Verbal notification requires communication with a live person; the organization may not leave a voicemail, ***and***
- The organization records the time and date of the notification and the staff member who spoke with the practitioner or member, ***and***
- The organization provides verbal notification within the time frames specified for an urgent concurrent or urgent preservice request.

For commercial, Medicare and Exchange decisions, if the organization provides verbal notification of a denial decision as specified for an urgent concurrent or urgent preservice request, it has an additional 3 calendar days following verbal notification to provide electronic or written notification.

For Medicaid decisions, providing verbal notification does not extend the electronic or written notification time frame.

Failure to follow filing procedures. If the member (or the member's authorized representative) does not follow the organization's reasonable filing procedures for requesting preservice or urgent concurrent coverage, the organization notifies the member (or the member's authorized representative) of the failure and informs them of the proper procedures to follow when requesting coverage.

- *For urgent preservice and concurrent decisions*, the organization notifies the member or practitioner (member's authorized representative) within 24 hours of receiving the request. Notification may be verbal, unless the member or practitioner requests written notification.
- *For nonurgent preservice decisions*, the organization notifies the member or the member's authorized representative within 5 calendar days of receiving the request.

The organization may not deny a nonurgent preservice, urgent preservice or urgent concurrent request that requires medical necessity review for failure to follow filing procedures.

The organization may deny a postservice request without conducting a medical necessity review—even if a medical necessity review is required (as outlined in UM 1, Element A)— if the member (or the member's authorized representative) does not follow the organization's reasonable filing procedures. The organization must provide the reason for the denial.

Use of practitioner web portals. The organization may provide electronic denial notifications to practitioners through a web portal if:

- The organization informs practitioners of the notification mechanism and their responsibility to check the portal regularly, ***and***
- The organization documents the date and time when the information was posted in the portal, ***and***
- The information posted in the portal meets the requirements in UM 4–UM 7. If the portal contains a link to the information on a specific site, it must include a site description that gives readers a clear idea of its topic and general content, ***and***

- The organization has an alternative notification method for practitioners who do not have access to the web portal.

Use of member web portals. The organization may provide electronic denial notifications to members through a web portal if:

- The organization documents the member's agreement to receive electronic notifications via the portal, ***and***
- The organization documents the date and time when the information was posted in the portal, ***and***
- Members receive notification that a new document or update is available in the portal when it is posted (e.g., text, email, other electronic notification), ***and***
- The information posted in the portal meets the requirements in UM 4–UM 7. If the portal contains a link to the information on a specific site, it must include a site description that gives readers a clear idea of its topic and general content, ***and***
- The organization has an alternative notification method for members who do not have access to the web portal or who do not agree to receive notifications via the portal.

Organizations that make both decisions and recommendations. Further instructions for file review are specified in the policies and procedures and the file review worksheet.

Examples **Failure to follow filing procedures**

- An organization's procedure is that members or practitioners submit UM requests in writing, but the member or practitioner files a request over the phone.
- An organization's procedure is that members or practitioners submit requests within a specific time frame, but the member or practitioner submits the request outside the time frame.

Element B: Notification of Behavioral Healthcare Decisions

The organization adheres to the following time frames for notification of behavioral healthcare UM decisions:

1. **For urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.**
2. **For urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.**
3. **For ~~commercial and Exchange~~ nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 7 ~~15~~ calendar days of the request.**
4. ~~**For Medicare and Medicaid nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 14 calendar days of the request.**~~
4. **For postservice decisions, the organization gives electronic or written notification of the**
~~5~~. **decision to members and practitioners within 30 calendar days of the request.**

Scoring

Met	Partially Met	Not Met
High (90-100%) on file review	Medium (60-89%) on file review	Low (0-59%) on file review

Data source Records or files

Scope of review

Product lines

This element applies to all product lines for First Surveys and Renewal Surveys.

NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product line files may be combined.

Documentation

For First Surveys and Renewal Surveys: NCQA reviews a random sample of up to 40 behavioral healthcare denial files resulting from medical necessity review for evidence of timeliness of notification.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

THIS IS A MUST-PASS ELEMENT.

This element applies to all behavioral healthcare denial determinations resulting from medical necessity review (as defined in *UM 1: Program Structure*, Element A).

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Definitions used when classifying UM requests

The organization uses the definitions stated in Element A.

Reclassification of behavioral requests that do not meet the definition of "urgent." All types of requests received while the member is receiving care may be reclassified as preservice or postservice if the request does not meet the definition of "urgent." This includes a request to extend a course of treatment beyond the time period or number of treatments previously approved by the organization. The request may be handled as a new request and decided within the time frame appropriate for the type of decision notification (i.e., preservice or postservice).

Factors 1–4 ~~5~~: **Timeliness of notification**

NCQA considers 24 hours to be equivalent to 1 calendar day and 72 hours to be equivalent to 3 calendar days.

NCQA measures timeliness of notification from the date when the organization receives the request from the member or the member's authorized representative, even if the organization does not have all the information necessary to make a decision, to the date when it notifies the member and practitioner, as applicable.

The organization notifies the member (or their authorized representative) and the member's attending or treating practitioner of the UM decision within the time frames specified in factors 1–4.

For urgent concurrent decisions, the organization may notify the provider (e.g., hospital, rehabilitation facility, DME, home health) or Utilization Review department staff, with the understanding that staff will inform the attending or treating practitioner.

The organization may address the notification to the attention of the attending or treating practitioner under certain circumstances. Refer to *Related information.*

The organization documents the date when it receives the request, and the date of the decision notification, in the UM file. The request is received when it arrives at the organization, even if it is not received by the UM department.

For organizations that do not communicate with members and practitioners, NCQA measures timeliness from when the request is received from the client.

For Medicare urgent requests only: NCQA measures timeliness of notification for urgent requests from the date when the appropriate department receives the request. The organization documents the date when the appropriate department receives the request, and the date of the decision notification, in the UM file.

If the organization sends written notice, NCQA uses the date on the notice as the notification date. If the organization does not retain copies of the written notice, it has other methods of documenting the notification date. If the organization uses electronic notification, NCQA uses the date when the notification was posted in the electronic system.

An organization may have procedures for ongoing review of urgent concurrent care it approved initially. For ongoing reviews, the notification period begins on the day of the review. The organization documents the date of the ongoing review and the decision notification in the UM denial file.

The organization may extend the decision time frame under certain circumstances. Refer to *Related information.*

Exceptions

This element is NA if all purchasers of the organization's services carve out or exclude behavioral healthcare.

Exceptions to member notification. NCQA does not require the organization to notify a member of:

- An urgent concurrent denial.
- An urgent preservice denial.
- A postservice (retrospective) denial if the member is not at financial risk.

For urgent denials, NCQA considers the attending or treating practitioner to be acting as the member's representative. During the file review process, NCQA assesses whether the decision notification time frames to the practitioner were appropriate.

Factor 3 is NA for the Medicare and Medicaid product lines.

Factors 4 is NA for the commercial and Exchange product lines.

Related information

An organization may have procedures for ongoing review of urgent concurrent care that was approved initially. For ongoing review, the notification period begins on the day of the review. The organization documents the date of the review and the decision notification in the UM denial file.

Addressing notices to the attention of the attending or treating practitioner.

For preservice and postservice decisions, if attending or treating practitioner information ~~on the attending or treating practitioner~~ was not provided with the request, or if the request was from a provider (e.g., facility)~~,~~ and not ~~rather than~~ from a practitioner, the organization makes at least two attempts to identify the practitioner, and documents its attempts in the UM file. Leaving a voicemail counts as one attempt. If the organization cannot identify the attending or treating practitioner, it addresses the notification "to the attention of the attending or treating practitioner" (in this case, the attending or treating practitioner's name is not required).

Notifying the practitioner. If information on the attending or treating practitioner was not provided with the request, or the request was from a provider (e.g., facility) rather than a practitioner, the organization makes two or more attempts to identify the practitioner and documents its attempts in the UM file. Leaving a voicemail counts as one attempt. If the organization cannot identify the attending or treating practitioner, it addresses the notification "to the attention of the attending or treating practitioner." In this case, the attending or treating practitioner's name is not required.

For urgent concurrent decisions, the organization may inform the provider's Utilization Review department staff without attempting to identify the attending or treating practitioner.

~~For urgent concurrent decisions, the organization may inform the hospital Utilization Review (UR) department staff without attempting to identify the treating practitioner, with the understanding that staff will inform the attending/treating practitioner.~~

~~In all cases, if the practitioner is not known, the organization must address the notification to the attention of the attending or treating practitioner; the practitioner name is not required.~~

Receiving requests after normal business hours. Due to the nature of urgent requests, the organization has procedures for accepting them after normal business hours. NCQA counts the time from the date when the organization receives the request, whether or not it is during business hours.

Postservice payment disputes. Postservice requests for payment initiated by a practitioner or a facility are not subject to review if the practitioner or facility has no recourse against the member for payment (i.e., the member is not at financial risk). Exclude denials of such requests from the file review universe.

Approving alternative services. If the organization approves an alternative to the service being requested, and the member or the member's authorized representative does not request or agree to the alternative service, the organization would be denying care that was originally requested; therefore, this is considered a denial and should be included in the file review universe. However, if the member or the member's authorized representative agrees to the alternative, and the care is authorized, the member or the member's authorized representative has essentially withdrawn the initial request; therefore, this is not considered a denial and should not be included in the file review universe.

Extending time frames. Members or their authorized representatives may agree to extend the decision-making time frame for urgent, preservice and postservice requests.

Extension conditions

<u>Factors 1, 2: Urgent concurrent and urgent preservice requests for Medicare and Medicaid product lines.</u>

For Medicare, the organization may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, ***or***
- The organization needs additional information, ***and***
    - Documents that it made at least one attempt to obtain the necessary information.
    - Notifies the member or the member's authorized representative of the delay.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

For Medicaid, the organization may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, ***or***
- The organization needs additional information, provided it documents that it made at least one attempt to obtain the necessary information.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

Factors 1, 2: Urgent concurrent and urgent preservice requests for commercial and Exchange product lines.

For commercial and Exchange, extensions are not allowed for urgent concurrent decisions.

For urgent preservice, the organization may extend the urgent preservice time frame once due to lack of information, for 48 hours, under the following conditions:

- Within 24 hours of receipt of the urgent preservice request, the organization asks the member or the member's representative for the information necessary to make the decision, ***and***
- The organization gives the member or the member's authorized representative at least 48 hours to provide the information, ***and***
- The extension period, within which a decision must be made by the organization, begins on the sooner of:
    - The date when the organization receives the member's response (even if not all of the information is provided), ***or***
    - The last date of the time period given to the member to provide the information, even if no response is received from the member or the member's authorized representative.

Factor 3: Nonurgent preservice requests for commercial and Exchange product lines. If the request lacks clinical information, the organization may extend the nonurgent preservice time frame for up to 15 calendar days, under the following conditions:

- Before the end of the time frame the organization asks the member or the member's representative for the information necessary to make the decision, ***and***
- The organization gives the member or the member's authorized representative at least 45 calendar days to provide the information.
- The extension period, within which a decision must be made by the organization, begins on the sooner of:
    - The date when the organization receives the member's response (even if not all of the information is provided), ***or***
    - The last date of the time period given to the member to supply the information, even if no response is received from the member or the member's authorized representative.

The organization may deny the request if it does not receive the information within the time frame, and the member may appeal the denial.

Factor 3 ~~4~~: Nonurgent preservice requests for Medicare and Medicaid product lines.

For Medicare, the organization may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, ***or***
- The organization needs additional information, ***and***
    - Documents that it made at least one attempt to obtain the necessary information.
    - Notifies the member or the member's authorized representative of the delay.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

For Medicaid, the organization may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, ***or***
- The organization needs additional information, provided it documents that it made at least one attempt to obtain the necessary information.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

Factor 4 ~~5~~: Postservice requests for commercial, Exchange and Medicaid product lines. If the request lacks clinical information, the organization may extend the postservice time frame for up to 15 calendar days, under the following conditions:

- Before the end of the time frame, the organization asks the member or the member's representative for the information necessary to make the decision, ***and***
- The organization gives the member or the member's authorized representative at least 45 calendar days to provide the information.
- The extension period, within which a decision must be made by the organization, begins on the sooner of:
    - The date when the organization receives the member's response (even if not all of the information is provided), ***or***
    - The last date of the time period given to the member to supply the information, even if no response is received from the member or the member's authorized representative.

The organization may deny the request if it does not receive the information within the time frame, and the member may appeal the denial.

Extension for other reasons. In a situation beyond the organization's control (e.g., waiting for an evaluation by a specialist), it may extend the nonurgent preservice and postservice time frames once, for up to 15 calendar days, under the following conditions:

- Within 15 calendar days of a nonurgent preservice request, the organization notifies the member (or the member's authorized

representative) of the need for an extension and the expected date of the decision.
- Within 30 calendar days of a postservice request, the organization notifies the member (or the member's authorized representative) of the need for an extension and the expected date of the decision.

For Medicare, extensions are not allowed for postservice requests.
Factors 1, 2: Verbal notification of denials. Verbal notification does not replace electronic or written notification of denial decisions, but when provided, the organization may extend the time frame for electronic or written notification for commercial, Medicare and Exchange decisions as described below.

- Verbal notification requires communication with a live person; the organization may not leave a voicemail, ***and***
- The organization records the time and date of the notification and the staff member who spoke with the practitioner or member, ***and***
- The organization provides verbal notification within the time frames specified for an urgent concurrent or urgent preservice request.

For commercial, Medicare and Exchange decisions, if the organization provides verbal notification of a denial decision as specified for an urgent concurrent or urgent preservice request, it has an additional 3 calendar days following verbal notification to provide electronic or written notification.

For Medicaid decisions, providing verbal notification does not extend the electronic or written notification time frame.

Failure to follow filing procedures. If the member (or the member's authorized representative) does not follow the organization's reasonable filing procedures for requesting preservice or urgent concurrent coverage, the organization notifies the member (or the member's authorized representative) of the failure and informs them of the proper procedures to follow when requesting coverage.

- *For urgent preservice and concurrent decisions*, the organization notifies the member or practitioner (member's authorized representative) within 24 hours of receiving the request. Notification may be verbal, unless the member or practitioner requests written notification.
- *For nonurgent preservice decisions*, the organization notifies the member or the member's authorized representative within 5 calendar days of receiving the request.

The organization may not deny a nonurgent preservice, urgent preservice or urgent concurrent request that requires medical necessity review for failure to follow filing procedures.

The organization may deny a postservice request without conducting a medical necessity review—even if a medical necessity review is required (as outlined in UM 1, Element A)—if the member (or the member's authorized representative) does not follow the organization's reasonable filing procedures. The organization must provide the reason for the denial.

Use of practitioner web portals. The organization may provide electronic denial notifications to practitioners through a web portal if:

- The organization informs practitioners of the notification mechanism and their responsibility to check the portal regularly, ***and***
- The organization documents the date and time when the information was posted in the portal, ***and***
- The information posted in the portal meets the requirements in UM 4–UM 7. If the portal contains a link to the information on a specific site, it must include a site description that gives readers a clear idea of its topic and general content, ***and***
- The organization must have an alternative method for practitioners who do not have access to the web portal.

Use of member web portals. The organization may provide electronic denial notifications to members through a web portal if:

- The organization documents the member's agreement to receive electronic notifications via the portal, ***and***
- The organization documents the date and time when the information was posted in the portal, ***and***
- Members receive notification that a new document or update is available in the portal when it is posted (e.g., text, email, other electronic notification), ***and***
- The information posted in the portal meets the requirements in UM 4–UM 7. If the portal contains a link to the information on a specific site, it must include a site description that gives readers a clear idea of its topic and general content, ***and***
- The organization has an alternative notification method for members who do not have access to the web portal or who do not agree to receive notifications via the portal.

Organizations that make both decisions and recommendations. Further instructions for file review are specified in the policies and procedures and the file review worksheet.

Examples

Failure to follow filing procedures

- An organization's procedure is that members or practitioners submit UM requests in writing, but the member or practitioner files a request over the phone.
- An organization's procedure is that members or practitioners submit requests within a specific time frame, but the member or practitioner submits the request outside the time frame.

Element C: Notification of Pharmacy Decisions

The organization adheres to the following time frames for notifying members and practitioners of pharmacy UM decisions:

1. **For commercial and Exchange urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of the request.**
2. **For Medicare Part B and Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of the request.**
3. **For commercial and Exchange urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.**
4. **For Medicare Part B and Medicaid urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of the request.**
5. **For commercial and Exchange nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 7 ~~15~~ calendar days of the request.**
6. **For Medicare Part B nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.**
7. **For Medicaid nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of the request.**
8. **For postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 30 calendar days of the request.**
9. **For Medicare Part D urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of receipt of the request.**
10. **For Medicare Part D nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of receipt of the request.**

11. For Medicare Part D postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 14 calendar days of receipt of the request.

Scoring

Met	Partially Met	Not Met
High (90-100%) on file review	Medium (60-89%) on file review	Low (0-59%) on file review

Data source Records or files

Scope of review

Product lines

This element applies to all product lines for First Surveys and *Renewal Surveys*.

NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product line files may be combined.

Factors 1–8 apply to commercial, Medicaid and Exchange product lines and Medicare Part B drugs.

Documentation

For First Surveys and Renewal Surveys: NCQA reviews a random sample of up to 40 pharmaceutical denial files resulting from medical necessity review for evidence of timeliness of notification.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

THIS IS A MUST-PASS ELEMENT.

This element applies to all pharmaceutical denial determinations resulting from medical necessity review (as defined in *UM 1: Program Structure,* Element A), whether the pharmaceutical is covered under an organization's medical benefit or its pharmacy benefit.

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Definitions used when classifying UM requests

The organization uses the definitions stated in Element A.

Reclassification of pharmaceutical requests that do not meet the definition of "urgent." All types of requests received while the member is receiving care may be reclassified as preservice or postservice if the request does not meet the definition

of “urgent.” This includes a request to extend a course of treatment beyond the time period or number of treatments previously approved by the organization. The request may be handled as a new request and decided within the time frame appropriate for the type of decision notification (i.e., preservice or postservice).

Factors 2, 4, 7: **Timeliness of Medicaid pharmacy notification**

For the Medicaid product line, drugs that meet the federal definition of “covered outpatient drugs” as stated in SSA 1927(k)(2), the organization sends its decision notification within 24 hours.

For the Medicaid product line, drugs that are excluded from the federal definition of “covered outpatient drugs,” as stated in SSA 1927(k)(3), the organization sends its decision notification within 72 hours for urgent concurrent requests and urgent preservice requests, and sends its decision notification within 14 calendar days for nonurgent preservice requests.

Factors 1–11: **Timeliness of pharmacy notification**

The organization notifies the member (or their authorized representative) and the member’s attending or treating practitioner of the UM decision within the time frames specified in factors 1–5.

For urgent concurrent decisions, the organization may notify the provider (e.g., hospital, rehabilitation facility, DME, home health) or Utilization Review department staff, with the understanding that staff will inform the attending or treating practitioner.

The organization may address the notification to the attention of the attending or treating practitioner under certain circumstances. Refer to *Related information.*

NCQA considers 24 hours to be equivalent to 1 calendar day and 72 hours to be equivalent to 3 calendar days.

NCQA measures timeliness of notification from the date when the organization receives the request from the member or the member’s authorized representative, even if the organization does not have all the information necessary to make a decision, to the date when it notifies the member and practitioner, as applicable.

The organization documents the date when it receives the request, and the date of the decision notification, in the UM file. The request is received when it arrives at the organization, even if it is not received by the UM department.

For organizations that do not communicate with members and practitioners, NCQA measures timeliness from when the request is received from the client.

For Medicare urgent requests only: NCQA measures timeliness of notification for urgent requests from the date when the appropriate department receives the request. The organization documents the date when the appropriate department receives the request, and the date of the decision notification, in the UM file.

If the organization sends written notice, NCQA uses the date on the notice as the notification date. If the organization does not retain copies of the written notice, it has other methods of documenting the notification date. If the organization uses electronic notification, NCQA uses the date when the notification was posted in the electronic system.

An organization may have procedures for ongoing review of urgent concurrent care it approved initially. For ongoing reviews, the notification period begins on the day of the review. The organization documents the date of the ongoing review and the decision notification in the UM denial file.

The organization may extend the decision time frame under certain circumstances. Refer to *Related information.*

Exceptions

This element is NA:

- If all purchasers of the organization's services carve out or exclude pharmaceutical management.
- For pharmaceutical approvals made at the pharmacy.

Exceptions *to member notification.* NCQA does not require the organization to notify a member of:

- An urgent concurrent denial.
- An urgent preservice denial.
- A postservice (retrospective) denial if the member is not at financial risk.

For urgent denials, NCQA considers the attending or treating practitioner to be acting as the member's representative. During the file review process, NCQA assesses whether the decision notification time frames to the practitioner were appropriate.

Factors 1–8 are NA for Medicare Part D drugs.

Factors 1, 3 and 5 are NA for Medicare and Medicaid product lines.

Factors 2 and 4 are NA for commercial and Exchange product lines.

Factor 6 is NA for commercial, Medicaid and Exchange product lines.

Factor 7 is NA for commercial, Medicare and Exchange product lines.

Factors 9–11 are NA for commercial, Medicaid and Exchange product lines and Medicare Part B drugs.

Related information

Notifying the practitioner. If attending or treating practitioner information ~~on the attending or treating practitioner~~ was not provided with the request, or if the request was from a provider (e.g., facility) and not ~~rather than~~ from a practitioner, the organization makes two or more attempts to identify the practitioner, and documents its attempts in the UM file. Leaving a voicemail counts as one attempt. If the organization cannot identify the attending or treating practitioner, it addresses the notification "to the attention of the attending or treating practitioner" (in this case, the attending or treating practitioner's name is not required).

For urgent concurrent decisions, the organization may inform the provider's Utilization Review department staff without attempting to identify the attending or treating practitioner.~~For urgent concurrent decisions, the organization may inform the hospital Utilization Review (UR) department staff without attempting to identify the treating practitioner, with the understanding that staff will inform the attending/treating practitioner.~~

~~In all cases, if the practitioner is not known, the organization must address the notification to the attention of the attending or treating practitioner; the practitioner name is not required.~~

Medicare Part B drugs (factors 2, 4, 6). For guidance on drugs covered under Medicare Part B, refer to the *Medicare Managed Care Manual, Chapter 4 - Benefits and Beneficiary Protections, 10.8 – Drugs that are Covered Under Original Medicare Part B.*

Medicare Part D drugs (factors 9–11). For guidance on drugs covered under Medicare Part D, refer to the *Medicare Prescription Drug Benefit Manual Chapter 6 – Part D Drugs and Formulary Requirements, 10.2 - Covered Part D Drugs.*

Alignment with CMS time frames.

- Factor 9: Medicare Part D urgent preservice decisions. The time frame corresponds to the CMS "expedited coverage" determination time frame.
- Factor 10: Medicare Part D nonurgent preservice decisions. The time frame corresponds to the CMS "standard coverage" determination time frame.
- Factor 11: Medicare Part D postservice decisions. The time frame corresponds to the CMS "request for reimbursement" time frame.

Receiving requests after normal business hours. Due to the nature of urgent requests, the organization has procedures for accepting them after normal business hours. NCQA counts the time from the date when the organization receives the request, whether or not it is during business hours.

Medications dispensed at the pharmacy. Requests for coverage of medications dispensed at a pharmacy may only be classified as urgent concurrent, urgent preservice or nonurgent preservice, depending on whether the request meets NCQA's definition of "urgent." Medications dispensed at the pharmacy may not be classified as postservice requests.

Postservice payment disputes. Postservice requests for payment initiated by a practitioner or a facility are not subject to review if the practitioner or facility has no

recourse against the member for payment (i.e., the member is not at financial risk). Exclude denials of such requests from the file review universe.

Approving alternative pharmaceuticals. If the organization approves an alternative to the service being requested and the member or the member's authorized representative does not request or agree to the alternative service, the organization would be denying care that was originally requested; therefore, this is considered a denial and should be included in the file review universe. However, if the member or the member's authorized representative agrees to the alternative and the care is authorized, the member or the member's authorized representative has essentially withdrawn the initial request; therefore, this is not considered a denial and should not be included in the file review universe.

Extending time frames for factors 1–8. Members or their authorized representatives may agree to extend the decision-making time frame for urgent, preservice and postservice requests.

Extension conditions

Factor 1: Urgent concurrent requests for commercial and Exchange product lines.

- The organization may extend the decision notification time frame if the request to extend urgent concurrent care was made less than 24 hours prior to, or any time after, the expiration of the previously approved period or number of treatments. The organization may treat the request to extend urgent concurrent care as urgent preservice and send a decision notification within 72 hours.
- The organization may extend the decision notification time frame if the request to approve additional days for urgent concurrent care is related to care not previously approved by the organization and the organization documents that it made at least one attempt and was unable to obtain the needed clinical information within the initial 24 hours after the request for coverage of additional days. In this case, the organization has up to 72 hours to make the decision.

Factors 2, 4: Urgent concurrent and urgent preservice requests for Medicaid product line. The organization may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, ***or***
- The organization needs additional information, provided it documents that it made at least one attempt to obtain the necessary information.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

Factor 3: Urgent preservice requests for commercial and Exchange product lines. The organization may extend the urgent preservice time frame once due to lack of information, for 48 hours, under the following conditions:

- Within 24 hours of receipt of the urgent preservice request, the organization asks the member or the member's representative for the information necessary to make the decision, ***and***

- The organization gives the member or the member's authorized representative at least 48 hours to provide the information, ***and***
- The extension period, within which a decision must be made by the organization, begins on the sooner of:
    - The date when the organization receives the member's response (even if not all of the information is provided), ***or***
    - The last date of the time period given to the member to provide the information, even if no response is received from the member or the member's authorized representative.

Factor 5: Nonurgent preservice requests for commercial and Exchange product lines. If the request lacks clinical information, the organization may extend the nonurgent preservice time frame for up to ~~15~~ 7 calendar days, under the following conditions:

- Before the end of the time frame the organization asks the member or the member's representative for the information necessary to make the decision, ***and***
- The organization gives the member or the member's authorized representative at least 45 calendar days to provide the information.
- The extension period, within which a decision must be made by the organization, begins on the sooner of:
    - The date when the organization receives the member's response (even if not all of the information is provided), ***or***
    - The last date of the time period given to the member to supply the information, even if no response is received from the member or the member's authorized representative.

The organization may deny the request if it does not receive the information within the time frame, and the member may appeal the denial.

Factor 7: Nonurgent preservice requests for Medicaid product line. The organization may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, ***or***
- The organization needs additional information, provided it documents that it made at least one attempt to obtain the necessary information.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

Factor 8: Postservice requests for commercial, Exchange and Medicaid product lines. If the request lacks clinical information, the organization may extend the postservice time frame for up to 15 calendar days, under the following conditions:

- Before the end of the time frame, the organization asks the member or the member's representative for the information necessary to make the decision, ***and***
- The organization gives the member or the member's authorized representative at least 45 calendar days to provide the information.
- The extension period, within which a decision must be made by the organization, begins on the sooner of:

- The date when the organization receives the member's response (even if not all of the information is provided), ***or***
- The last date of the time period given to the member to supply the information, even if no response is received from the member or the member's authorized representative.

The organization may deny the request if it does not receive the information within the time frame, and the member may appeal the denial.
Extension for other reasons. In a situation beyond the organization's control (e.g., waiting for an evaluation by a specialist), it may extend the nonurgent preservice and postservice time frames once, for up to 15 calendar days, under the following conditions:

- Within 15 calendar days of a nonurgent preservice request, the organization notifies the member (or the member's authorized representative) of the need for an extension and the expected date of the decision.
- Within 30 calendar days of a postservice request, the organization notifies the member (or the member's authorized representative) of the need for an extension and the expected date of the decision.

Extending time frames for Medicare Part B and D for factors 2, 4, 6, 9–11—Alignment with CMS. In accordance with the Medicare Prescription Drug Manual, Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, extensions are not allowed.

For Medicare, extensions are not allowed for postservice requests.
Factors 1–4: Verbal notification of denials. Verbal notification does not replace electronic or written notification of denial decisions, but when provided, the organization may extend the time frame for electronic or written notification for commercial, Medicare and Exchange decisions as described below.

- Verbal notification requires communication with a live person; the organization may not leave a voicemail, ***and***
- The organization records the time and date of the notification and the staff member who spoke with the practitioner or member, ***and***
- The organization provides verbal notification within the time frames specified for an urgent concurrent or urgent preservice request.

For commercial, Medicare and Exchange decisions, if the organization provides verbal notification of a denial decision as specified for an urgent concurrent or urgent preservice request, it has an additional 3 calendar days following verbal notification to provide electronic or written notification.

For Medicaid decisions, providing verbal notification does not extend the electronic or written notification time frame.

For Medicare Part D drugs, initial verbal notification of a decision may be made within the specified time frames. Written notification must be made no later than 3 calendar days after verbal notification.

Failure to follow filing procedures. If the member (or the member's authorized representative) does not follow the organization's reasonable filing procedures for

requesting preservice or urgent concurrent coverage, the organization notifies the member (or the member's authorized representative) of the failure and informs them of the proper procedures to follow when requesting coverage.

- *For urgent preservice and concurrent decisions*, the organization notifies the member or practitioner (member's authorized representative) within 24 hours of receiving the request. Notification may be verbal, unless the member or practitioner requests written notification.
- *For nonurgent preservice decisions*, the organization notifies the member or the member's authorized representative within 5 calendar days of receiving the request.

The organization may not deny a nonurgent preservice, urgent preservice or urgent concurrent request that requires medical necessity review for failure to follow filing procedures.

The organization may deny a postservice request without conducting a medical necessity review—even if a medical necessity review is required (as outlined in UM 1, Element A)—if the member (or the member's authorized representative) does not follow the organization's reasonable filing procedures. The organization must provide the reason for the denial.

Use of practitioner web portals. The organization may provide electronic denial notifications to practitioners through a web portal if:

- The organization informs practitioners of the notification mechanism and their responsibility to check the portal regularly, ***and***
- The organization documents the date and time when the information was posted in the portal, ***and***
- The information posted in the portal meets the requirements in UM 4–UM 7. If the portal contains a link to the information on a specific site, it must include a site description that gives readers a clear idea of its topic and general content, ***and***
- The organization must have an alternative method for practitioners who do not have access to the web portal.

Use of member web portals. The organization may provide electronic denial notifications to members through a web portal if:

- The organization documents the member's agreement to receive electronic notifications via the portal, ***and***
- The organization documents the date and time when the information was posted in the portal, ***and***
- Members receive notification that a new document or update is available in the portal when it is posted (e.g., text, email, other electronic notification), ***and***
- The information posted in the portal meets the requirements in UM 4–UM 7. If the portal contains a link to the information on a specific site, it must include a site description that gives readers a clear idea of its topic and general content, ***and***

- The organization has an alternative notification method for members who do not have access to the web portal or who do not agree to receive notifications via the portal.

Organizations that make both decisions and recommendations. Further instructions for file review are specified in the policies and procedures and the file review worksheet.

Examples **Failure to follow filing procedures**

- An organization's procedure is that members or practitioners submit UM requests in writing, but the member or practitioner files a request over the phone.
- An organization's procedure is that members or practitioners submit requests within a specific time frame, but the member or practitioner submits the request outside the time frame.

UM 9: Appropriate Handling of Appeals

The organization adjudicates member appeals in a thorough, appropriate and timely manner.

Intent

The organization has a full and fair process for resolving member disputes and responding to members' requests to reconsider a decision they find unacceptable regarding their care and service.

Element D: Notification of Appeal Decision/Rights

An NCQA review of the organization's internal appeal files indicates notification to members of the following:

1. **Specific reasons for the appeal decision, in easily understandable language.**
2. **A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based.**
3. **Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, upon request.**
4. **Notification that the member is entitled to receive reasonable access to and copies of all documents, free of charge, upon request.**
5. **A list of titles and qualifications, including specialties, of individuals participating in the appeal review.**
6. **A description of the next level of appeal, either within the organization or to an independent external organization, as applicable, along with any relevant written procedures.**
7. **For final internal appeal notices, members are not required to bear costs of the IRO, including filing fees.**

Scoring

Met	Partially Met	Not Met
High (90-100%) on file review for at least 5	High (90-100%) or medium (60-89%) on file review for 7 factors	Low (0-59%) on file review for any factor

factors and medium (60-89%) on file review for any remaining factors		

Data source Records or files

Scope of review

Product lines

This element applies to all product lines for First Surveys and *Renewal Surveys*. NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product line files may be combined.

Documentation

For First Surveys and Renewal Surveys: NCQA reviews a random sample of up to 40 upheld appeal files for evidence that appeal notices meet all 6 factors.

Appeal files include appeals of any denial of a request for coverage, whether or not the denial resulted from medical necessity review (e.g., medical, behavioral health, pharmacy or personal care services). This includes all medical necessity and benefit decision appeals.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

THIS IS A MUST-PASS ELEMENT.

This element evaluates handling of appeals according to the policies required by *UM 8: Policies for Appeals.* This element applies to all medical necessity and benefit decision appeals.

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Factor 1: **The appeal decision**

The appeal decision notification states the reason for upholding the denial in terms specific to the member's condition or request and in language that is easy to understand, so the member and practitioner understand why the organization upheld the appeal decision and have enough information to file the next level of appeal.

An appropriately written notification includes a complete explanation of the grounds for the upheld appeal decision, in language that a layperson would understand, and

does not include abbreviations, acronyms or health care procedure codes that a layperson would not understand.

The organization is not required to spell out abbreviations/acronyms if they are clearly explained in lay language.

To illustrate, for the abbreviation DNA, spelling out is “DNA (deoxyribonucleic acid),” and explaining is “a DNA test looks at your genetic information.”

Upheld appeal notifications sent only to practitioners may include technical or clinical terms.

The organization may send a single notice to the member and practitioner that includes the specific reason for upholding the denial, in language that would be easily understood by the member. The notice may also include, in a separate section, additional clinical or technical language directed toward a practitioner.

For appeals resulting from medical necessity review of out-of-network requests, the reason for upheld appeal decision must explicitly address the reason for the request (e.g., if the request is related to accessibility issues, that may be impacted by the clinical urgency of the situation, the appeal decision must address whether or not the requested service can be obtained within the organization’s accessibility standards).

Factor 2: **Reference to UM criterion**

The appeal notification references the specific criterion used to make the denial decision. The criterion used and referenced is specific to the member's condition or to the requested services.

The criterion must be identifiable by name and must be specific to an organization or source (e.g., ABC PBM’s Criteria for Treatment of Hypothyroidism with Synthroid or Criteria Company Inc.’s Guidelines for Wound Treatment).

If it is clear that the criterion is attributable to the organization, it is acceptable to state, “our Criteria for XXX” (e.g., our Criteria for Treating High Cholesterol with Lipitor).

Because benefit documents are often large and complex, the organization must direct members to the information using the section title or page number.

For appeals of denials resulting from medical necessity review of out-of-network requests, criteria may be excerpted from benefit documents that govern out-of-network coverage, organization policies specifying circumstances where out-of-network coverage will be approved or clinical criteria used to evaluate the member’s clinical need relative to available network providers and services. The reference must specifically support the rationale for the decision and must relate to the reason for the request.

Factor 3: **Availability of criterion**

The appeal notification informs the member or the member’s authorized representative, that the criterion used to make the decision is available upon

request. Providing the criterion, or an excerpt specific to the denial reason, with the appeal decision notification is also acceptable. NCQA scores this factor “Yes” if the criterion or excerpt is included in the decision notice or if the notification states that the criterion or excerpt is included as an attachment.

Factor 4: **Access to and copies of documents**

No additional explanation required.

Factor 5: **Titles and qualifications**

The upheld appeal decision notification identifies all reviewers who participated in making the appeal decision, including the same-or-similar specialist reviewer, when applicable, as they provide specific clinical knowledge and experience that affects the decision.

For each individual, the notice includes:

- *For a benefit appeal:* The title (position or role in the organization).
- *For a medical necessity appeal:* The title (position or role in the organization), qualifications (clinical credentials such as MD, DO, PhD, physician) and specialty (e.g., pediatrician, general surgeon, neurologist, clinical psychologist).

The organization is not required to include individuals’ names in the written notification.

Factor 6: **Additional appeal rights**

The notification describes members’ additional appeal rights if their appeal is denied.

If the next level of appeal is independent external review, the notification includes a statement that members are not required to bear costs of the IRO, including any filing fees, unless state law mandates that members pay an IRO filing fee.

If the organization instructs the member to send an appeal directly to an IRO, including MAXIMUS, factor 6 requirements are met if members are told where to send the appeal and the relevant time frames, if applicable.

NEW Factor 7: **Cost of review**

If state law mandates that members pay an IRO filing fee, the organization receives credit for this factor if it provides the state’s language. This factor applies to final-level appeals.

Exceptions

Factors 3, 4 and 5 are NA for Medicare Part D appeals.

For factor 4, the "free of charge" component is NA for Medicare appeals.

Factor 7 is NA:

- For appeal notifications before July 1, 2025.
- If the organization had no final internal appeals during the look-back period.
- For appeals by members covered by Medicare, Medicaid or the Federal Employees Health Benefit (FEHB) Program.
- For appeals by members in self-funded accounts.
- If the employer mandates that its employees go through its external appeal process.

Related information

Identification of appeal reviewers. The appeal decision notification sent to the member does not need to include the names of the individuals who participated in the appeal decision. The organization is not required to provide a signature on the appeal decision notice sent to the member.

Medicare appeals. For Medicare appeal files, factors 1–6 are met if there is evidence that the organization sent the upheld denial to MAXIMUS.

Examples None.

UM 11: Procedures for Pharmaceutical Management

The organization ensures that its procedures for pharmaceutical management, if any, promote the clinically appropriate use of pharmaceuticals.

Intent

The organization develops, regularly reviews and updates policies and procedures for pharmaceutical management based on sound clinical evidence.

Element B: Pharmaceutical Restrictions/Preferences

Annually, and within 30 calendar days after updates, the organization communicates to members and prescribing practitioners:

1. **A list of pharmaceuticals, including restrictions and preferences.**
2. **How to use the pharmaceutical management procedures.**
3. **An explanation of limits or quotas.**
4. **How prescribing practitioners must provide information to support an exception request.**
5. **The organization's process for generic substitution, therapeutic interchange and step-therapy protocols.**

Scoring

Met	Partially Met	Not Met
The organization meets 4-5 factors	The organization meets 2-3 factors	The organization meets 0-1 factors

Data source Documented process, Reports, Materials

Scope of review

Product lines

This element applies to all product lines for Interim Surveys, First Surveys and Renewal Surveys.

Documentation

NCQA reviews the organization's pharmaceutical procedures and lists.

For First Surveys and Renewal Surveys, NCQA also reviews materials distributed to members and prescribing practitioners. The organization may also provide reports to show evidence of distribution to members and practitioners.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: At least once during the prior year.

For Renewal Surveys: 24 months.

Explanation

This element applies to all pharmaceuticals, whether they are covered under an organization's medical benefit or its pharmacy benefit, including, but not limited to:

- All pharmaceuticals, ~~whether or not they are~~ <u>even those not</u> listed in the organization's formularies.
  - Including open and closed formularies.
- Pharmaceuticals administered or dispensed in all settings (e.g., inpatient, outpatient, at the pharmacy, at home).
- Customized pharmaceutical management procedures for a distinct set or class of pharmaceuticals, including injectables.

The organization has pharmaceutical management procedures that promote the clinically appropriate use of pharmaceuticals, unless otherwise carved out by all purchasers of the organization's services.

Pharmaceutical and pharmaceutical management procedures communicated to members and prescribers include information on, as applicable:

- Covered pharmaceuticals.
- Copayment information, including tiers.
- Pharmaceuticals that require prior authorization.
- Limits on refills, doses or prescriptions.
- Use of generic substitution, therapeutic interchange or step-therapy protocols.
- How formulary updates are communicated, and how often, if the organization has scheduled formulary updates.

Distribution of pharmaceutical procedures and updates

The organization distributes pharmaceutical procedures to all members and practitioners.

The organization may limit communication of updates to “negative” formulary changes (i.e., changes that result in restrictions or replacements) and may limit such communications to affected members and their practitioners.

The organization distributes pharmaceutical management procedures and updates by mail, fax or email, or on its website if it informs members and prescribing practitioners that the information is available online. The notice must include a description specific enough to give readers a clear idea of the topic and the general content and must include a link or direction to the specific information. The organization may group or summarize the information by theme. The organization mails pharmaceutical management procedures and updates to prescribing practitioners and affected members who do not have fax, email or internet access.

Factors 1–3

No additional explanation required.

Factor 4: **Exception request**

If the organization administers a closed formulary, there is an exception process for circumstances where the formulary does not adequately accommodate members’ clinical needs, and a process for prescribing practitioners to submit information that supports exception requests.

Factor 5: **Process for generic substitution, therapeutic interchange and step-therapy protocols**

The organization's procedures regarding generic substitution, therapeutic interchange and step-therapy are outlined and communicated to members and prescribers. The organization is not required to communicate procedures that are not in use within its benefit.

Exceptions

This element is NA if all purchasers of the organization’s services carve out or exclude pharmaceutical management.

Factor 4 is NA for organizations that do not administer a closed formulary for their members.

Examples

Pharmaceutical management procedures

Member and practitioner newsletters or handbooks describe changes to generic substitution, therapeutic interchange or step-therapy protocols.

UM 13: Delegation of UM

If the organization delegates UM activities, there is evidence of oversight of the delegated activities.

Intent

The organization remains responsible for and has appropriate structures and mechanisms to oversee delegated UM activities.

NEW Element E: Non-NCQA Accredited Delegate Review

For delegation arrangements that have been in effect for more than 12 months, with organizations that are not NCQA Accredited or Certified, the organization:

1. **Completes an annual audit for each delegate.**
2. **Identifies corrective actions, as applicable.**
3. **Implements corrective actions or plans to implement corrective actions, as applicable.**

Scoring

Met	Partially Met	Not Met
The organization meets 2-3 factors for all non-NCQA Accredited or Certified delegates	The organization meets 1 factor for all non-NCQA Accredited or Certified delegates	The organization meets 0 factors for all non-NCQA Accredited or Certified delegates

Data source

Report

Scope of review

Product lines

This element applies to all product lines for Interim Surveys, First Surveys and Renewal Surveys.

Documentation

For All Surveys: NCQA reviews the delegation worksheet submitted in IRT by the organization for evidence that the organization completed its annual delegate audit(s) and provided the annual audit dates, whether or not a corrective action plan was needed.

NCQA also reviews the delegation worksheet for evidence that the organization provided the date of the implemented corrective action plan or the planned implementation date of the corrective action plan, for each delegate that is not NCQA Accredited or Certified.

Look-back period

For Interim Surveys and First Surveys: Once during the prior year.

For Renewal Surveys: 24 months.

Explanation

This element may not be delegated.

This element applies to all delegates that are not NCQA Accredited or Certified.

Factor 1: **Annual audit review**

The organization completes an annual audit for all its delegates, as required in UM 13, Element C. For this factor, the organization completes the delegation worksheet in IRT, and documents when it completed its annual audits for each non-NCQA Accredited/Certified delegate. ***Factor 2:*** **Identification of corrective actions**

The organization identifies corrective actions for each non-NCQA Accredited/Certified delegate, as applicable, such as updating policies and procedures, conducting training or making system changes. The organization documents that it identified corrective actions in the delegation worksheet submitted in IRT.

Factor 3: **Implementing corrective actions**

Either the organization or the delegate may implement corrective actions, as needed.

The organization documents implementation dates of corrective actions for all NCQA Accredited/Certified delegates. The documented implementation date may be a future date.

For example, if the organization identifies:

- *Updating policies and procedures* as a corrective action, it documents when policies and procedures were updated or the date when planned updates will occur.
- *Training* as a corrective action, it documents when training occurred or the date when planned training will occur.
- *System changes* as a corrective action, it documents when system changes were made or the date when planned system changes will occur.

Exceptions

This element is NA if:

- The organization does not delegate UM activities.
- All delegates are NCQA-Accredited/Certified organizations.

Examples None.