Quality Management and Improvement

QI 1: Program Structure and Operations

The organization clearly defines its quality improvement (QI) structures and processes, assigns responsibility to appropriate individuals and operationalizes its QI program.

Intent

The organization has the QI infrastructure necessary to improve the quality and safety of clinical care and services it provides to its members and to oversee the QI program.

Element A: QI Program Structure

The organization's written program description outlines the following:

1. **The QI program structure.**
2. **Substantial involvement of a designated behavioral healthcare practitioner in the QI program.**
3. **Oversight of QI activities by the QI Committee.**
4. **Involvement of representatives of relevant medical systems or other health care practitioners in the QI program.**

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 4 factors~~	~~The organization meets 3 factors~~	~~The organization meets 2 factors~~	~~The organization meets 1 factor~~	~~The organization meets 0 factors~~

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

Scope of review NCQA reviews the organization's QI program description in place throughout the look-back period.

Look-back period *For Initial Surveys:* 6 months.

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.

The QI program description

The QI program description is a comprehensive document or a set of interconnected documents, that describe, in plain language, the QI program's governance, scope, goals, measurable objectives, structure and responsibilities.

Factor 1: **Program structure**

The program description includes the following information about the QI structure:

- The QI program's functional areas and their responsibilities.
- Reporting relationships of QI Department staff, QI Committee and any subcommittee.
- Resources and analytical support.
- Delegated QI activities, if the organization delegates QI activities.
- Collaborative QI activities, if any.

Factor 2: **Involvement of designated behavioral healthcare practitioner**

The program description describes the role of the designated behavioral healthcare practitioner in the QI program, which includes participating in or advising the QI Committee or a subcommittee that reports to the QI Committee.

The behavioral healthcare practitioner must be a medical doctor or have a clinical PhD or PsyD, and may be a medical director, clinical director or participating practitioner.

Factor 3: **QI Committee oversight**

The program description defines the role, function and reporting relationships of the QI Committee and subcommittees, including committees associated with oversight of delegated activities.

- If participating practitioners are not members of the QI Committee, they are involved in a clinical subcommittee or relevant ad hoc task forces.

Note: *Participating practitioners are external to the organization and are part of the organization's network.*

- If organization staff are not members of the QI Committee, they are involved in multidisciplinary work groups or subcommittees.

Factor 4: **Representative input**

The organization includes representatives of relevant medical delivery systems or other health care practitioners, as appropriate, providing input on the QI program through the QI Committee or through other formal mechanisms.

Exception

Factor 4 is NA if the organization does not have a formal relationship with the medical delivery system through contracts, delegation or other arrangements.

Related information

Collaborative activities. If the organization collaborates with other organizations on QI activities:

- It includes information about the collaborative and QI activities performed in the QI program description.
- It has communication and feedback mechanisms between the collaborative group and its internal QI Committee.

If the collaborative group has its own QI committee for carrying out functions, the organization may consider it to be a subcommittee of the QI Committee.

Examples None.

Element B: Annual Work Plan

The organization documents and executes a QI program annual work plan that reflects ongoing activities throughout the year and addresses:

1. **Yearly planned QI activities and objectives.**
2. **Time frame for each activity's completion.**
3. **Staff members responsible for each activity.**
4. **Monitoring of previously identified issues.**
5. **Evaluation of the QI program.**

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 5 factors~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization meets 0-4 factors~~

Met	Partially Met	Not Met
The organization meets 5 factors	No scoring option	The organization meets 0-4 factors

Data source Documented process, Reports

Scope of review

For Initial Surveys: NCQA reviews the organization's QI program annual work plan, including documented progress on activities.

For Renewal Surveys: NCQA reviews the organization's most recent and previous year's QI program annual work plans, including documented progress on activities.

NCQA cites two data sources because a documented process (e.g., the QI program annual work plan) is reviewed for all survey types.

For Initial Surveys and Renewal Surveys: The organization may supplement a documented process with reports that show progress on annual activities, if the activities are not already included in the work plan.

Look-back period

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

For Renewal Surveys: 24 months.

Explanation

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

The QI program annual work plan is a dynamic document that covers a full year of planned activities and objectives.

Factor 1: **Yearly planned QI activities and objectives**

The organization identifies and includes activities in the work plan that address:

- Quality of clinical care.
- Safety of clinical care.
- Quality of service.

- Members' experience.

Factor 2: **Time frame for each activity's completion**

A time frame for completion must be included for each activity. Time frames must be specific (e.g., date, month, quarter, as opposed to frequency).

Factor 3: **Staff responsible for each activity**

The work plan must specify the staff responsible for activities. Staff are not required to be listed by name; they may be listed by title or role. The list may be limited to activity leads.

Factor 4: **Monitoring previously identified issues**

The QI work plan includes periodic or ongoing monitoring of issues identified in prior years that the organization determines require additional follow-up.

Factor 5: **Evaluation of the QI program**

Annual evaluation of the QI program must be listed as a specific activity on the work plan, with a stated time frame and identify the staff responsible for the evaluation. Staff are not required to be listed by name; they may be listed by title or role.

Exceptions

None.

Examples None.

Element C: Annual Evaluation

The organization conducts an annual written evaluation of the QI program that includes the following information:

1. **A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service.**
2. **Trending of measures of performance in quality and safety of clinical care and quality of service.**
3. **Evaluation of the overall effectiveness of the QI program, including progress toward influencing networkwide safe clinical practices.**

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 3 factors~~	~~The organization meets 2 factors~~	~~No scoring option~~	~~The organization meets 1 factor~~	~~The organization meets 0 factors~~

Met	Partially Met	Not Met

The organization meets 2-3 factors	No scoring option	The organization meets 0-1 factors

Data source Reports

Scope of review

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

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

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.

The organization annually evaluates how well it met its performance goals and objectives for improving the quality and safety of clinical care and services specified within its QI program description. The organization summarizes its findings in an annual report.

Factor 1: **Completed and ongoing QI activities**

The annual evaluation summarizes completed and ongoing QI activities outlined in the QI program description.

Factor 2: **Trending of QI measure results**

The annual evaluation includes trending of QI measure results over time and comparison against performance objectives defined within the QI program description. The organization uses charts, graphs or tables, or a combination of these, to display trended data.

Results do not need to be trended for Initial Surveys.

Factor 3: **Evaluation of effectiveness**

The annual evaluation includes the organization's determination of the overall effectiveness of the QI program and its progress in meeting safe clinical practice goals, based on performance in all aspects of the QI program. The summary of effectiveness addresses:

- Adequacy of QI program resources.
- QI Committee and subcommittee structure.
- Practitioner participation and leadership involvement in the QI program.
- Need to restructure or change the QI program for the subsequent year.

Exceptions

None.

Examples

Annual written evaluation content

The title of each QI program initiative described in the work plan.

- A description of the program.
- The program's major accomplishments.

- Appropriate measures trended over time, including:
  - Satisfaction data.
  - Organization-specific data.
  - Clinical measures.
- Barriers to achieving objectives.
- Recommended interventions for overcoming issues and barriers.
- Whether planned yearly activities were completed and objectives were met.
- Whether the QI program will be restructured or changed in the subsequent year.

Element D: QI Committee Responsibilities

The organization's QI Committee:

1. **Recommends policy decisions.**
2. **Analyzes and evaluates the results of QI activities.**
3. **Ensures practitioner participation in the QI program through planning, design, implementation or review.**
4. **Identifies needed actions.**
5. **Ensures follow-up, as appropriate.**

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 5 factors~~	~~The organization meets 4 factors~~	~~The organization meets 3 factors~~	~~The organization meets 1-2 factors~~	~~The organization meets 0 factors~~

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

Data source Reports

Scope of review

For All Surveys: Factors 1–5 must be performed in each year of the look-back period.

For Initial Surveys: NCQA reviews up to three sets of QI Committee minutes within the look-back period. If three sets of meeting minutes are not available, NCQA reviews all committee minutes within the look-back period.

For Renewal Surveys: NCQA reviews up to three sets of QI Committee minutes for each year of the look-back period. If three sets of meeting minutes are not available, NCQA reviews all committee minutes for each year of the look-back period.

Look-back period

For Initial Surveys: 6 months.

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

The organization's QI Committee oversees the development and implementation of the QI program and QI functions in the organization.

Associated committees and subcommittees may also participate in these activities.

Factor 1: **Policy recommendations**

The QI Committee recommends and revises, or oversees recommendations and revisions to, policies for effective operation of the QI program and achievement of QI program objectives.

Factor 2: **Analysis and evaluation of QI activities**

The QI Committee oversees the analysis and evaluation of the QI program and assesses the results. The committee is not required to be directly involved in quantitative and qualitative analysis, but in its oversight role, reviews the analysis and evaluation of QI activities of other committees or staff.

Factor 3: **Practitioner participation**

The QI Committee facilitates participating practitioner involvement in the QI program activities through attendance and discussion in relevant QI committee or QI subcommittee meetings or on ad hoc task forces.

Participating practitioners are representative of the specialties in the organization's network.

If participating practitioners are not members of the QI committee, they are involved in a clinical subcommittee or relevant ad hoc task force.

Note: *Participating practitioners are external to the organization and part of the organization's network.*

Factor 4: **Identify needed actions**

The QI Committee identifies actions to improve quality, prioritizes them based on their significance and chooses which to pursue, or oversees these functions if performed by an associated committee or subcommittee.

Factor 5: **Follow-up**

The QI Committee reviews and evaluates the organization's actions to determine their effectiveness.

Exceptions

None.

Related information

Collaborative activities. If the organization collaborates with other organizations on QI activities:

- It includes information about the collaborative and QI activities performed in the QI program description.

- It has communication and feedback mechanisms between the collaborative group and its internal QI Committee.

If the collaborative group has its own QI committee for carrying out functions, the organization may consider it to be a subcommittee of the QI Committee.

Examples

***Factor 1:* Common QI committee recommendations**

Approve:

- The QI program description and work plan.
- Practitioner availability and access standards.
- Selected quality performance measures or initiatives.
- Performance goals, objectives and thresholds.
- Selection criteria for complex case management.
- Policies and procedures covered in the MBHO standard categories.
- Establish the composition of and the operating guidelines for QI subcommittees.

***Factor 3:* Relevant QI activities for practitioner participation**

- Develop and review clinical practice guidelines.
- Analyze member experience results.
- Select QI initiatives to improve access to care and services.

Element E: Sharing Evaluation Results

The organization annually shares results of its current evaluation with relevant clients or other medical delivery systems.

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets the requirement~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization does not meet the requirement~~

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

Data source Reports, Materials

Scope of review

For Initial Surveys: NCQA reviews evidence of the most recent annual distribution of the program evaluation to clients or other delivery systems.

For Renewal Surveys: NCQA reviews evidence of the most recent and previous year's annual distributions of the program evaluation to clients or other delivery systems.

Look-back period

For Initial Surveys: 6 months.

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.

The organization may distribute comprehensive information on the evaluation or include the information in an executive summary.

Exception

This element is NA if the organization does not have a formal relationship with the medical delivery system through contracts, delegation or another method.

Examples

None.

~~Element F: Promoting Organizational Diversity, Equity and Inclusion~~

~~**The organization:**~~

~~**1. Promotes diversity in recruiting and hiring.**~~

~~**2. Offers training to employees on cultural competency, bias or inclusion.**~~

~~Summary of Changes~~

- ~~Adjusted scoring to "Met," "Partially Met" and "Not Met."~~

~~Scoring~~

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

~~Data source~~

~~Documented process, Materials~~

~~Scope of review~~

~~*For Initial Surveys:* NCQA reviews the organization's policies and procedures for promoting diversity in recruiting and hiring and for offering training to employees.~~

~~*For Renewal Surveys:*~~

- ~~*For factor 1:* NCQA reviews the organization's policies and procedures or materials in place throughout the look-back period for promoting diversity in recruiting and hiring.~~
- ~~*For factor 2:* NCQA reviews the organization's policies and procedures in place throughout the look-back period for offering training to employees, and also reviews evidence demonstrating that the organization offered the training at least once during the prior 24 months.~~

~~Look-back period~~

~~*For Initial Surveys:* 6 months.~~

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

~~Explanation~~

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

~~***Factor 1:*** **Promotes diversity in recruiting and hiring~~

The organization describes how its recruiting and hiring processes promote a diverse workforce.

Note: This factor is specific to the organization's recruiting and hiring processes, and does not apply to practitioner network management.

***Factor 2:* Offer training on cultural competency, bias or inclusion**

The organization offers at least one training to all employees on cultural competence, bias or inclusion. The organization determines training type and frequency.

Exceptions

None.

Related information

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 2, it provides access to the vendor's documentation. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under *QI 12: Delegation of QI.* NCQA evaluates the vendor's documentation against the requirements. Refer to *Vendors* in *Appendix 3: Delegation and Automatic Credit Guidelines.*

Examples

***Factor 1*: Promoting diversity in recruiting and hiring**

The organization includes the following in its policies and procedures for promoting diversity in recruiting and hiring:

- Require that candidates interviewed for a position in the organization include at least one person from an underrepresented demographic and one person from an underrepresented gender.
- Create an inclusive job description:
  - Use gender neutral language.
  - Reduce requirements to "must-haves."
  - Indicate a salary range.
  - Emphasize the organization's commitment to diversity and inclusion.
- Blind-review resumes.
- Hold hiring decision makers responsible for representation growth (i.e., diversity) in teams and in the organization.
- Dedicate resources to recruiting underrepresented groups (e.g., individuals with disabilities).
- Deploy technology that screens for bias in job descriptions and postings.
- Require interview panels to include interviewers from underrepresented groups or genders.

QI 2: Health Services Contracting

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

Intent

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

Element A: Practitioner Contracts

Contracts with practitioners specifically require that practitioners cooperate with QI activities.

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets the requirement~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization does not meet the requirement~~

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

Data source Documented process, Materials

Scope of review NCQA reviews three active practitioner contracts executed within the look-back period. If the contracts do not address the requirement, NCQA reviews a practitioner manual or the organization's policies and procedures as an extension of the contract in certain circumstances. Refer to ***Related information****.*

Look-back period *For Initial Surveys:* 6 months.

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

This element applies to contracts between the organization and its practitioners, medical groups, independent practice associations (IPA) and rental networks.

Providing the contract for review

The organization may attach the entire contract or only the relevant pages from the contract that address this element (e.g., the first page with the practitioner name, text that meets the requirement and the signature page). The organization may provide contract documents when it submits the completed survey tool or may have the documents reviewed onsite.

Cooperation with QI activities

Practitioner contracts specify that practitioners cooperate with the organization's QI activities to improve the quality of care and services and member experience.

Cooperation includes collection and evaluation of data and participation in the organization's QI programs.

Exception

This element is NA for Renewal Surveys if the organization provides evidence that there were no new contracts executed during the look-back period.

Related information

Use of practitioner manual or organization's policies. The organization may use its practitioner manual or policies as evidence of performance against this element in the following circumstances.

- Practitioner contracts specify that the manual or policy is an extension of the contract and that practitioners must abide by the conditions set forth in the contract and in the manual or policy.
- The manual or policy includes the requirements specified in the element.

The organization includes an addendum addressing requirements not included in the contract.

Examples None.

Element B: Provider Contracts

Contracts with organization providers specifically require that providers cooperate with QI activities.

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets the requirement~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization does not meet the requirement~~

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

Data source Documented process, Materials

Scope of review NCQA reviews three active provider contracts, at least one from a hospital, executed within the look-back period. If the contracts do not address the

requirement, NCQA reviews a provider manual or the organization's policies and procedures as an extension of the contract in certain circumstances. Refer to *Related information.*

Look-back period

For Initial Surveys: 6 months.

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

Providing the contract for review

The organization may attach the entire contract or only the relevant pages from the contract that address this element (e.g., the first page with the provider name, text that meets the requirement and the signature page). The organization may provide contract documents when it submits the completed survey tool, or may have the documents reviewed onsite.

Cooperation with QI activities

Provider contracts specify that providers cooperate with the organization's QI activities, including collection of performance measurement data and participation in the organization's clinical and service measure QI programs.

Exception

This element is NA for Renewal Surveys if the organization provides evidence that there were no new contracts executed during the look-back period.

Related information

Use of provider manual or organization's policies. The organization may use its provider manual or policies as evidence of performance against this element in the following circumstances.

- Provider contracts specify that the manual or policy is an extension of the contract and that providers must abide by the conditions set forth in the contract and in the manual or policy.
- The manual or policy includes the required language.

The organization includes an addendum addressing requirements not included in the contract.

Examples

None.

QI 3: Coordination of Behavioral Healthcare (Former CC 1)

The organization monitors the continuity and coordination of care that members receive across the behavioral healthcare network and takes action, as necessary, to improve and measure the effectiveness of these actions.

Intent

The organization uses information at its disposal to facilitate and measure the effectiveness of improvement actions related to continuity and coordination of behavioral healthcare across its delivery system.

Element A: Data Collection

The organization annually identifies opportunities to improve coordination across the continuum of behavioral healthcare services by:

1. **Collecting data.**
2. **Conducting quantitative and qualitative analysis of data to identify improvement opportunities.**

Summary of Changes

- This element was formerly CC 4, Element A.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 2 factors~~	~~No scoring option~~	~~The organization meets 1 factor~~	~~No scoring option~~	~~The organization meets 0 factors~~

Met	Partially Met	Not Met
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 Renewal Surveys: NCQA reviews the organization's most recent and previous year's annual data collection and analysis reports.

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.

Factor 1: **Data collection**

The organization collects data to assess coordination of care across settings or transitions in care.

Factor 2: **Quantitative and qualitative analysis**

For initial measurement, the organization conducts an annual quantitative and qualitative analysis of data from factor 1.

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

Refer to *Appendix 5: Glossary* for the full definition of and requirements for quantitative analysis and qualitative analysis.

Exceptions

None.

Examples None.

Element B: Opportunities for Coordination

The organization annually selects at least one opportunity to improve coordination of behavioral healthcare in each of the following categories:

1. **Exchange of information across the continuum of behavioral healthcare services.**
2. **Access and follow-up with appropriate behavioral healthcare practitioners in the network.**
3. **Appropriate use of psychotropic medications.**
4. **Special needs of members with serious mental illness or serious emotional disturbance.**

Summary of Changes

- This element was formerly CC 4, Element B.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 2 factors~~	~~No scoring option~~	~~The organization meets 1 factor~~	~~No scoring option~~	~~The organization meets 0 factors~~

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 *For Initial Surveys:* NCQA reviews the organization's most recent report on opportunities for improvement.

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

year's reports on opportunities for improvement.

Look-back period

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

For Renewal Surveys: 24 months, at least once during the prior year for factor 4.

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.

Selecting opportunities for improvement

The organization uses quantitative and qualitative analyses to prioritize and select opportunities for improvement from the information collected and analyzed in Element A.

The organization identifies multiple areas, or measures, for improvement, based on its analysis. The organization selects four opportunities for improvement and describes its reasons for the selections.
NCQA considers each area or measure selected for improvement as one opportunity, and counts only one opportunity per measure for factors 1–4. Opportunities may address areas or measures related to transitions or settings and are not required to address both.

Because opportunities for improvement can change with each analysis, the organization may present different opportunities for each annual analysis.

***Factor 1:* Exchange of information across the continuum**

The organization identifies an opportunity to improve exchange of information across the continuum of behavioral healthcare that focuses on any or all of the following:

- Accuracy of the information.
- Sufficiency of the information.
- Timeliness of the information.
- Frequency of the information.
- Clarity of the information.

The organization meets factor 1 if behavioral healthcare practitioners can access each other's notes through a fully integrated electronic health record (EHR). NCQA considers an EHR to be fully integrated if it is implemented for all participating behavioral healthcare practitioners.

***Factor 2:* Access and follow-up with appropriate practitioners**

No explanation required.

***Factor 3:* Appropriate use of psychotropic medications**

The organization identifies an opportunity to improve behavioral health practitioner adherence to prescribing guidelines. Efforts to improve the HEDIS measures *Antidepressant Medication Management (AMM)* or *Follow-Up Care for Children Prescribed ADHD Medication (ADD, ADD-E)* meet the requirements of this factor.

***Factor 4:* Members with serious mental illness or serious emotional disturbance**

The organization identifies an opportunity to improve issues of continuity and coordination of services for members with serious mental illness (SMI) or serious emotional disturbance (SED).

Exceptions

None.

Examples None.

Element C: Improving Coordination

The organization improves coordination of behavioral healthcare by taking action annually on:

1. **The first opportunity identified in Element B.**
2. **The second opportunity identified in Element B.**
3. **The third opportunity identified in Element B.**
4. **The fourth opportunity identified in Element B.**

Summary of Changes

- This element was formerly CC 4, Element C.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 3-4 factors~~	~~The organization meets 2 factors~~	~~No scoring option~~	~~The organization meets 1 factor~~	~~The organization meets 0 factors~~

Met	Partially Met	Not Met
The organization meets 2-4 factors	No scoring option	The organization meets 0-1 factors

Data source Reports, Materials

Scope of review *For Initial Surveys:* NCQA reviews the organization's most recent annual report or dated material showing actions taken.

For Renewal Surveys: NCQA reviews the organization's most recent and previous year's annual reports or dated materials showing actions taken.

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

For Renewal Surveys: 24 months.

Explanation For this element, NCQA does not accept activities related to coordination between medical care and behavioral healthcare, as required in *CC 2: Collaboration Between Behavioral Healthcare and Medical Care.*

***Factors 1–4*: Acting to improve**

The organization acts on at least one opportunity for each of four distinct opportunities from Element B. The same action may address more than one identified opportunity.

Actions taken relate directly to the cause of the deficiency identified in the

qualitative analysis.

Exceptions

None.

Examples

Actions that address continuity and coordination issues

- Prompt psychiatrists to send summaries of recommendations to nonphysician behavioral healthcare practitioners.
- Alter the appointment system to maximize member access to the same practitioners, for continuity.
- Educate inpatient discharge planners or Home Health Agencies on how to give instructions.

Element D: Measuring Effectiveness

The organization annually measures the effectiveness of improvement actions taken for:

1. **The first opportunity identified in Element C.**
2. **The second opportunity identified in Element C.**
3. **The third opportunity identified in Element C.**
4. **The fourth opportunity identified in Element C.**

Summary of Changes

- This element was formerly CC 4, Element D.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 3-4 factors~~	~~The organization meets 2 factors~~	~~The organization meets 1 factor~~	~~No scoring option~~	~~The organization meets 0 factors~~

Scoring

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

Data source Reports

Scope of review NCQA reviews the organization's most recent and previous year's measurement reports analyzing the effectiveness of actions taken to improve the opportunities.

Look-back period *For Renewal Surveys:* 24 months.

Explanation

Measurement cycle

To meet each factor, the organization must measure the effectiveness of its actions from each of the two annual cycles (i.e., remeasure twice). A baseline measurement, analysis and intervention must precede each remeasurement; therefore, the factor requires two full cycles of measurement, analysis and

intervention, followed by one additional remeasurement and analysis.

Measuring effectiveness

The organization measures the effectiveness of improvement actions taken for opportunities in Element C.

The organization may measure effectiveness by repeating the original measurement or may use defined variables to measure performance of identified issues, collecting data on one of the following:

- Activities.
- Events.
- Occurrences.
- Outcomes.

Measures are based on standards of care or practice guidelines that include objective clinical criteria from authoritative sources, such as:

- Clinical literature.
- Consensus panels.
- HEDIS measures.
- Measures that are part of the organization's ongoing monitoring.

Measures may be designed for a focused study or for an activity targeted to improve a process of care.

Methodology

The organization uses valid methodology that allows comparison to the initial measurement or direct measurement of the impact of an action, defining the following for each measure:

- The numerator and denominator.
- The sampling methodology.
- The sample size calculation.
- The measurement periods and seasonality effects.

Quantitative and qualitative analysis

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

Refer to *Appendix 5: Glossary* for the full definition of and requirements for quantitative analysis and qualitative analysis.

Exception

This element is NA for Initial Surveys.

Related information

Collaborative activities. Data collection, analysis, actions and measurement of effectiveness may occur in the aggregate at the collaborative group level under the following conditions:

- The organization is involved in the collaborative efforts.
- The collaborative measure is relevant to the organization's population.
- Samples are representative of the collaborative organizations, but are not required to be stratified for each organization. All eligible members

from each participating organization are eligible for the sampling frame.

- Opportunities for improvement can be identified at the collaborative level for all participating organizations.

If appropriate, collaborative interventions may be treated as a pilot program. Such pilot interventions meet the element only if they have been rolled out in full to the entire eligible population.

Intermediate measures. The organization may evaluate effectiveness of an intervention by using the same measure specification used for the initial measurement to remeasure, or by conducting an intermediate measurement. An intermediate measurement can evaluate processes or outcomes related to the intervention.

Examples

Intermediate measure. Organization A's goal is to increase its screening rate by encouraging members to schedule a screening appointment. Its intermediate measurement of effectiveness is "the percentage of member contacts that resulted in scheduled appointments." The organization will measure the intervention's success at increasing screening until the next annual measurement cycle.

QI 4: Collaboration Between Behavioral Healthcare and Medical Care (Former CC 2)

The organization collaborates with relevant medical delivery systems to monitor, improve and measure the effectiveness of actions related to coordination between behavioral and medical care.

Intent

The organization collaborates with relevant providers and uses information at its disposal to coordinate behavioral healthcare and medical care and to measure the effectiveness of these actions.

Element A: Data Collection

The organization annually collects data about the following opportunities for collaboration between medical care and behavioral healthcare:

1. **Exchange of information.**
2. **Appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in primary care.**
3. **Appropriate use of psychotropic medications.**
4. **Management of treatment access and follow-up for members with coexisting medical and behavioral disorders.**

Summary of Changes

- This element was formerly CC 2, Element A.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 4 factors~~	~~The organization meets 3 factors~~	~~The organization meets 2 factors~~	~~The organization meets 1 factor~~	~~The organization meets 0 factors~~

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, Materials

Scope of review

For Initial Surveys: NCQA reviews the organization's evidence of collaboration (e.g., joint meeting minutes, communications) on data collection and most recent annual data collection report.

For Renewal Surveys: NCQA reviews the organization's evidence of collaboration (e.g., joint meeting minutes, communications) on data collection and the most recent and previous year's annual data collection reports.

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.

The organization demonstrates collaboration between its behavioral healthcare delivery system and medical care delivery system. Collaboration with a medical care system for this element is not considered delegation. The organization may collaborate on medical care and behavioral healthcare across its clients.

Factor 1: **Exchange of information**

The exchange of information is bidirectional. The organization collects data on exchange of information between behavioral healthcare and relevant medical delivery systems (e.g., medical/surgical specialists, organizational providers) measuring any or all of the following:

- Accuracy of the information.
- Sufficiency of the information.
- Timeliness of the information.
- Frequency of the information.
- Clarity of the information.

The organization meets the requirements of factor 1 if medical and behavioral healthcare practitioners can access each other's notes through a fully integrated electronic health record (EHR). NCQA considers an EHR to be fully integrated if it is implemented for all participating medical and behavioral health practitioners.

Factor 2: **Diagnosis, treatment and referral of behavioral disorders**

The organization collects data on:

- Behavioral disorders that may have been misdiagnosed or treated improperly, ***or***
- Referrals that were unnecessary, too early, too late or to the incorrect type of behavioral healthcare practitioner.

Factor 3: **Appropriate use of psychotropic medications**

The organization collects data on behavioral and medical practitioner adherence to prescribing guidelines.

Factor 4: **Management of coexisting medical and behavioral conditions**

The organization collects data on issues of managing medical and behavioral health conditions and where management across the continuum of care is an issue.

The intent is to collect data on both treatment access and follow-up services for members with coexisting medical and behavioral conditions.

Exception

This element is NA if the organization does not have a formal relationship with the medical delivery system through contracts, delegation or another method.

Related information

Use of HEDIS measures. Organizations may use HEDIS results that address

collaboration between behavioral healthcare and medical care to identify relevant clinical issues. Although a HEDIS measure may be relevant for more than one factor, the results of any HEDIS measure may be used for only one factor.

Note: *The use of HEDIS measure results alone may not meet the intent of the element because the results may not evaluate collaboration between behavioral healthcare and medical care. However, measure results may be used to identify a coordination of care area, or measure that goes beyond HEDIS results.*

Examples

Factor 1: **Exchange of information**

- Surveys of behavioral healthcare practitioners and other practitioners about their satisfaction with the frequency/timeliness/content of information exchanged between the two parties.
- Evaluation of solicited or unsolicited practitioner reports on communication between behavioral healthcare and medical practitioners, including protection of privacy.

Factor 2: **Diagnosis, treatment and referral**

- Data on the use of primary care guidelines for treating or making referrals for treatment of problems such as eating disorders, depression, postpartum depression, substance abuse or ADHD.
- Collaboration on use of the HEDIS measure *Antidepressant Medication Management (AMM).*
- Collaboration on use of the HEDIS measure *Follow-Up Care for Children Prescribed ADHD Medication (ADD).*

Factor 3: **Psychotropic medication use**

- Analysis of pharmaceutical utilization data for appropriate use of a psychotropic medication.
- Evaluation of psychotropic medication utilization data on issues related to multiple-prescribing practitioners.
- Collaboration on use of the HEDIS measure *Antidepressant Medication Management (AMM).*
- Collaboration on use of the HEDIS measure *Follow-Up Care for Children Prescribed ADHD Medication (ADD)*.
- Results of the organization's documented process for approving use of psychotropic medications in individual situations.
- Results of technology assessments to evaluate emerging psychotropic medications.

Factor 4: **Managing coexisting conditions**

- Data on the frequency of behavioral healthcare consultations with medical or surgical inpatients with secondary or tertiary mental health or substance abuse diagnoses.
- Data on the frequency of treatment and follow-up visits following mental health or substance abuse diagnoses.
- Pharmaceutical data on medication interactions to assess coordination of care for coexisting medical and behavioral problems.
- Collaboration on use of the HEDIS measure *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)*.
- Collaboration on use of the HEDIS measure *Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)*.
- Collaboration on use of the HEDIS measure *Diabetes Screening for People*

With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD).

- Collaboration on use of the HEDIS measure *Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM).*

Element B: Collaboration Between Behavioral Healthcare and Medical Care

The organization annually conducts activities to improve collaboration between behavioral healthcare and medical care, including:

1. **Collaborating with medical delivery systems.**
2. **Quantitative and qualitative analysis of data to identify improvement opportunities.**
3. **Identifying and selecting one opportunity for improvement from Element A.**
4. **Identifying and selecting a second opportunity for improvement from Element A.**
5. **Taking collaborative action to address one identified opportunity for improvement from Element A.**
6. **Taking collaborative action to address a second identified opportunity for improvement from Element A.**

Summary of Changes

- This element was formerly CC 2, Element B.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 5-6 factors~~	~~The organization meets 4 factors~~	~~The organization meets 3 factors~~	~~The organization meets 1-2 factors~~	~~The organization meets 0 factors~~

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

Data source Documented process, Reports, Materials

Scope of review

For Initial Surveys: NCQA reviews the organization's evidence of collaboration (e.g., joint meeting minutes, communications) on data collected in Element A, analyses, opportunities and actions.

For Renewal Surveys: NCQA reviews the organization's most recent and previous year's annual collaborations (e.g., joint meeting minutes, communications) on data collected in Element A, analyses, opportunities and actions.

For factors 5 and 6: NCQA reviews reports. Depending on the action taken to address identified opportunities, NCQA may also review a documented process or materials.

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.

***Factor 1:* Collaboration**

The organization collaborates with medical delivery systems to identify opportunities to improve continuity of care.

***Factor 2:* Quantitative and qualitative analysis**

For initial measurement, the organization conducts quantitative analysis of data and collaborates to conduct qualitative analysis of data.
For remeasurement, the organization conducts quantitative analysis, and collaborates to conduct qualitative analysis if quantitative analysis demonstrates that stated goals were not met.

Refer to *Appendix 5: Glossary* for the full definition of and requirements for quantitative analysis and qualitative analysis.

***Factors 3, 4:* Identifying and selecting opportunities**

Working collaboratively, the organization identifies multiple areas for improvement based on its analysis. The organization selects two opportunities for improvement and describes its reasons for the selections. Opportunities relate directly to findings of the qualitative analysis.

The organization may identify multiple opportunities per area (e.g., factor) from Element A for factors 3 and 4.

Because opportunities for improvement can change with each analysis, the organization may present different opportunities for each annual cycle.

***Factors 5, 6:* Acting to improve**

The organization acts on at least two opportunities for improvement from Element A to improve coordination of care between medical care and behavioral healthcare during each annual cycle. Interventions relate directly to the cause of the deficiency identified in the qualitative analysis.

Exception

This element is NA if the organization does not have a formal relationship with the medical delivery system through contracts, delegation or another method.

Related information

Collaboration through patient-centered medical home (PCMH) initiative. The use of a medical home initiative meets one opportunity for collaboration between behavioral healthcare and medical care in Element B if:

- The initiative is a direct result of the data collected in Element A and the analysis performed to meet Element B, factors 1 and 2, ***and***
- The organization provides evidence of active support for the PCMH model during the previous 12 months.

NCQA defines “active support” as any of the following:

- Helping with application fees for NCQA PCMH Recognition (beyond the NCQA program’s sponsor discount).
- Helping practices transform into a medical home.
- Providing other incentives for NCQA PCMH Recognition, such as pay-for-performance.

- Using NCQA PCMH Recognition as a criterion for inclusion in a restricted or tiered network.
- Reporting Recognition status in the practitioner directory.

The organization can receive credit for a second opportunity if it can provide evidence of an analysis that the medical home initiatives can meet additional opportunities.

Automatic credit does not apply if the organization uses a medical home initiative to meet the requirements.

Example

Opportunities for collaboration

- Improve the process for members to authorize sharing of behavioral healthcare information with primary care practitioners.
- Develop or implement primary care guidelines for assessing, treating and referring common behavioral problems.
- Increase practitioner satisfaction with feedback from other practitioners.
- Improve procedures for treating hospitalized members with coexisting medical and behavioral conditions.
- Improve identification and management of elderly members with multiple behavioral healthcare medications and potentially inappropriate dosages.
- Educate primary care practitioners about appropriate indications for referring patients with hyperactivity disorder or depression to behavioral healthcare practitioners.
- Provide tools to facilitate communication between behavioral healthcare practitioners and primary care practitioners.
- Hold quarterly meetings with the medical health care organization to develop coordination activities.

Documentation of collaboration

- QI Committee evaluation of collaboration activities.
- Participation of behavioral healthcare practitioners on the organization's QI Committee or on QI teams that report to the QI Committee.
- Joint meetings of the organization/client QI Committees.
- Exchange of ideas between the organization/client QI Committees (e.g., minutes, reports, questionnaires).

Activities for continuity and coordination of care

- Establish a system with behavioral healthcare practitioners for communicating members' prescribed medications to their primary care practitioners.
- Develop and implement a prevention program for a behavioral healthcare disorder commonly managed in the primary care setting.
- Place behavioral healthcare practitioners in high-volume or key primary care settings.

***Factors 5, 6*: Collaborative action**

Actions may include updating policies and procedures or materials communicated to practitioners that were revised during the look-back period.

Element C: Measuring Effectiveness

The organization annually measures the effectiveness of improvement actions taken for:

1. **The first opportunity identified in Element B.**
2. **The second opportunity identified in Element B.**

Summary of Changes

- This element was formerly CC 2, Element C.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 2 factors~~	~~No scoring option~~	~~The organization meets 1 factor~~	~~No scoring option~~	~~The organization meets 0 factors~~

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

Data source Reports

Scope of review NCQA reviews the organization's most recent and previous year's annual effectiveness report for two prioritized opportunities.

Look-back period *For Renewal Surveys:* 24 months.

Explanation

Measurement cycle

To meet each factor, the organization must measure the effectiveness of its actions from each of the two annual cycles (i.e., remeasure twice). A baseline measurement, analysis and intervention must precede each remeasurement; therefore, the factor requires two full cycles of measurement, analysis and intervention, followed by one additional remeasurement and analysis.

Measuring effectiveness

The organization may measure effectiveness by repeating the original measurement or may use defined variables to measure performance of identified issues, collecting data on one of the following:

- Activities.
- Events.
- Occurrences.
- Outcomes.

Measures are based on standards of care or practice guidelines that include objective clinical criteria from authoritative sources, such as:

- Clinical literature.
- Consensus panels.
- HEDIS measures.
- Measures that are part of the organization's ongoing monitoring.

Measures may be designed for a focused study or for an activity targeted to improve a process of care.

Methodology

The organization uses valid methodology that allows comparison to the initial measurement or direct measurement of the impacts of an action, defining the following for each measure:

- The numerator and denominator.
- The sampling methodology.
- The sample size calculation.
- The measurement periods and seasonality effects.

Quantitative and qualitative analysis

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

Refer to *Appendix 5: Glossary* for the full definition of and requirements for quantitative analysis and qualitative analysis.

Exceptions

This element is NA:

- If the organization does not have a formal relationship with the medical delivery system through contracts, delegation or another method.
- For Initial Surveys.

Related information

Intermediate measures. The organization may evaluate effectiveness of an intervention by using the same measure specification used for the initial measurement to remeasure, or by conducting an intermediate measurement. An intermediate measurement can evaluate processes or outcomes related to the intervention.

Examples

Intermediate measure. Organization A's goal is to increase its screening rate by encouraging members to schedule a screening appointment. Its intermediate measurement of effectiveness is "the percentage of member contacts that resulted in scheduled appointments." The organization will measure the intervention's success at increasing screening until the next annual measurement cycle.

QI 9: Clinical Practice Guidelines

The organization is accountable for adopting clinical practice guidelines relevant to its members for the provision of acute and chronic behavioral healthcare services.

Intent

The organization uses clinical practice guidelines to help practitioners and members make decisions about appropriate health care for specific clinical circumstances.

Element A: Adopting Relevant Guidelines

The organization adopts evidence-based clinical practice guidelines for at least three behavioral conditions, with at least one guideline addressing children and adolescents, by:

1. **Establishing the clinical basis for each guideline.**
2. **Updating each guideline at least every 2 years.**

Summary of Changes

- No changes to this element.

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	No scoring option	The organization meets 1 factor	No scoring option	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review NCQA reviews the organization's clinical practice guidelines in place throughout the look-back period and evidence of updating the guidelines, as applicable, within in the look-back period.

For factor 2, NCQA reviews the organization's policies and procedures for updating the guidelines if all guidelines are less than 2 years old.

Look-back period *For Initial Surveys:* 6 months.

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.

The organization provides evidence that it meets each factor for all three guidelines to receive credit for the factor.

Factor 1: **Adopting and establishing guidelines**

The organization's QI Committee, other designated clinical committee or medical director approves clinical practice guidelines.

The organization adopts at least three preventive or nonpreventive behavioral health guidelines. At least one guideline must address children and adolescents. If the organization's population does not include children and adolescents, all three guidelines must address the adult population.
The organization uses one of the following in adopting its clinical practice guidelines:

- Scientific evidence, ***or***
- Professional standards, ***or***
- Expert opinion.

The organization adopts guidelines from recognized sources or feedback of board-certified practitioners from appropriate specialties that would use the guideline. Evidence of appropriate specialties involvement may come through:

- Participation on a committee, ***or***
- The organization's consideration of comments from practitioners to whom guidelines were circulated.

In large regional and national organizations, a central office may develop clinical practice guidelines adopted from recognized sources or through input of board-certified practitioners from appropriate specialties (not necessarily from the local network).

Factor 2: **Updating guidelines**

The organization reviews its guidelines against clinical evidence at least every 2 years, or more frequently if national guidelines change within the 2-year period.

For Renewal Surveys, the organization presents guidelines older than 24 months at the time of the survey.

Exceptions

None.

Related information

Out of scope. This element does not include:

- UM criteria or guidelines that address medical necessity decision making.
- Treatment-record documentation criteria.

Collaborative activities. If the organization collaborates with other organizations to develop guidelines, either the collaborative group or the organization may review and update the guidelines.

Examples

Factor 1: **Adopting guidelines**

The organization reviewed its analysis of complex case management (QI 8, Element I), and the conclusions from the analysis in QI 9, Element B, QI 10, Element C and QI 11, Element A, to determine practice issues.

Analysis of the data and discussions with practitioners resulted in development of the following guidelines:

- Screening for Depression in People With Diabetes.
- Screening and Treatment of Attention Deficit Hyperactivity Disorder (ADHD).

Recognized sources

- Professional medical associations:
  - American Medical Association.
  - American Board of Psychiatry and Neurology.
  - American Psychiatric Association.
  - American Academy of Pediatrics.

- Voluntary health organizations:
  - American Diabetes Association.
  - American Heart Association.
- NIH Centers and Institutes:
  - National Institute of Mental Health.

Element B: Performance Measurement

The organization annually measures performance against at least two important aspects of each of the three clinical practice guidelines.

Summary of Changes

- No changes to this element.

Scoring

100%	80%	50%	20%	0%
The organization annually measures performance against at least 2 important aspects of 3 guidelines	The organization annually measures performance against at least 2 important aspects of 2 guidelines	The organization annually measures performance against at least 2 important aspects of 1 guideline	No scoring option	The organization performed inadequate measurement against guidelines

Data source

Reports

Scope of review

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

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

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.

The organization measures two aspects of the clinical process of care covered in each guideline (a total of six aspects). Applicable audited HEDIS results may be used to measure performance. Audited HEDIS results meet the requirement for evidence-based and sound methodology.

The organization provides evidence that it measures performance against at least two important aspects of each guideline to receive credit for the element.

NCQA encourages the organization to measure more than the two required aspects of performance. Assessment may be population or practice based. The organization may choose to measure performance against different guidelines in succeeding years; it is not necessary to continue measuring performance against the same two guidelines every year.

Analysis

Using valid methodology, the organization collects data on practitioners' adherence to adopted guidelines showing areas or parts of the guidelines that are not being used.

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.

Analysis may be population or practice based.

Refer to *Appendix 5: Glossary* for the full definition of and requirements for quantitative analysis and qualitative analysis.

Exception

This element is NA for Initial Surveys if all guidelines are less than 6 months old at the time of the survey.

Related information

Collaborative activities. If the organization collaborates with other organizations to develop guidelines, measurement of guideline performance may occur at the collaborative level, using aggregate data. If data collection is practice based, the sample used is representative of the collaborative organizations.

Examples

Analysis and intervention of depression measures

- *Antidepressant Medication Management (AMM)*:
  - Measurement 1: Effective Acute Phase Treatment.
  - Measurement 2: Effective Continuation Phase Treatment.

Collection of data conforms to the HEDIS technical specifications.

Results for the two measures for the last 3 years are as follows:

Phase	Goal	Year 1	Year 2	Current Year
Acute Phase	55.0%	49.8%	50.6%	53.9%
Continuation Phase	50.0%	39.3%	38.7%	39.1%

The organization saw significant improvement in meeting the acute phase aspect of the depression measure guideline, but not in meeting the continuation phase aspect of the depression measure. Although performance results improved over a 3-year trend, the organization had not met its goals.

Further investigation revealed that results in lower-income areas were significantly lower than in other parts of the service area. Practitioner surveys revealed that transportation barriers was the major reason for lower results. The organization's director of pharmacy initiatives, QI director and members of the QI Committee reviewed analysis results and participated in the development of interventions. The organization developed interventions to address transportation barriers that included arranging for transportation assistance and developing educational materials to inform members of available public transit options.

QI 5 ~~10~~: Clinical Measurement Activities (former QI 10)

The organization identifies, monitors and works to improve clinical issues relevant to its members.

Intent

The organization uses measurement of quality in clinical care and drives continuing improvement that positively affects member care.

~~Element A: Process for Data Collection and Integration~~

~~**The organization has a documented process for collecting and integrating the following data sources:**~~

1. ~~**Outpatient claims.**~~
2. ~~**Inpatient claims.**~~
3. ~~**Demographic data.**~~
4. ~~**Electronic health records.**~~
5. ~~**Pharmacy data.**~~
6. ~~**Laboratory results.**~~

~~Summary of Changes~~

- ~~This standard was formerly QI 10.~~
- ~~Adjusted scoring to "Met," "Partially Met" and "Not Met."~~

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

~~Data source~~ ~~Documented process~~

~~Scope of review~~ ~~NCQA reviews the organization's process for data collection and integration of the data sources used and the integration method used.~~

~~Look-back period~~ ~~*For Initial Surveys:* 6 months.~~

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

~~Explanation~~ ~~Data integration is combining data from multiple sources and databases. Data may be combined from multiple systems and sources (e.g., claims, pharmacy, EHRs), across sites of care (e.g., inpatient, ambulatory, home) and across domains (e.g., clinical, business, operational). The organization must have the capability to integrate the data for all factors, even if it does not currently have access to some of the listed data sources.~~

~~***Factors 1–3*: Outpatient and inpatient claims, demographic or encounter data~~

~~No additional explanation required.~~

***Factor 4:* Electronic health records**

Integrating EHR data from one practice or provider meets the intent of this requirement.

***Factors 5, 6:* Pharmacy data and laboratory results**

No additional explanation required.

Exceptions

None.

Examples

Process flow describing data sources and model for integrating the data.

***Factor 4:* EHR integration**

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

Element B: Clinical Quality Improvements

Using valid methodology, the organization works to improve clinical issues by annually:

1. **Identifying at least three relevant clinical issues.**
2. **Collecting data appropriate for the clinical issues.**
3. **Analyzing the collected data.**
4. **Identifying opportunities for improvement and deciding which to pursue.**
5. **Implementing interventions to improve performance.**
6. **Measuring the effectiveness of interventions.**

Summary of Changes

- This standard was formerly QI 10.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

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

Data source

Documented process, Reports

Scope of review

NCQA evaluates up to nine QIAs and scores the three that most meet the factors of the element. The organization prioritizes its QIAs for review.

For Initial Surveys: NCQA also reviews the organization's most recent annual data collection, evaluation and identification of opportunities report.

For Renewal Surveys: NCQA also reviews the organization's most recent and previous year's annual data collections, evaluation and identification of opportunities reports.

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. NCQA refers to the methodology to improve clinical issues as "quality improvement activities (QIA)."

Factor 1: **Identifying clinical issues**

The organization assesses the demographic characteristics and health risks of its covered population and the data collected in Element A, and chooses at least three relevant clinical issues that reflect the health needs of significant groups within the population. One of the clinical issues may be a preventive health issue.

Factor 2: **Collecting data**

The organization selects any combination of process or outcomes measures that have significant bearing on the identified clinical issues and collects data specific to the measures.

Factor 3: **Quantitative and qualitative analysis**

For initial measurement, the organization conducts quantitative and qualitative analysis of data that compares results against goals.

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

The organization establishes an explicit, quantifiable performance goal or benchmark for each measure.

As processes for delivering clinical care continue to improve, performance goals move toward optimal performance levels. It is not sufficient for an organization to have a goal of improving a rate; the organization must designate a specific rate as a goal or benchmark.

Refer to *Appendix 5: Glossary* for the full definition of and requirements for quantitative analysis and qualitative analysis.

Factor 4: **Identifying opportunities for improvement**

The organization uses its analysis results to prioritize opportunities. The opportunities may be different each time the organization measures and analyzes the data. The organization identifies one or more opportunities to improve for each of the three QIAs.

There may only be one clinical improvement per disease state and only one clinical improvement for the same measure or disease state across product lines.

Issues that involve only reducing utilization, such as decreasing the length of inpatient stays for depression, do not meet the intent of this element, but the data may be a starting point to identify quality issues.

Factor 5: **Implementing interventions**

The organization's interventions address barriers or specific causes for not meeting goals or benchmarks. Interventions are of sufficient strength and specificity that there is likelihood that they contribute to a measurable improvement when performance is measured again, and must not be so generic that they could have been initiated (or would have been initiated) in the absence of specific measurement and analysis.

NCQA evaluates each intervention by assessing:

- Whether the intervention was strong enough to have had a positive effect.
- Whether the intervention related specifically to the identified barriers to improvement or to the causes of not meeting the goal.
- Whether the intervention began early enough to affect performance at remeasurement.

If there is a series of interventions, the timing of each may influence the outcome.

Factor 6: **Measuring effectiveness**

The organization uses defined variables to measure performance of identified issues, and collects data on one of the following:

- Activities.
- Events.
- Occurrence.
- Outcomes.

Measures are based on standards of care or practice guidelines that include objective clinical criteria from authoritative sources, such as:

- Clinical literature.
- Consensus panels.
- HEDIS measures.
- Measures that are part of the organization's ongoing monitoring.

Measures may be designed for a focused study or for an activity targeted to improve a process of care.

Measurement cycle

To meet each factor, the organization must measure the effectiveness of its actions from each of the two annual cycles (i.e., remeasure twice). A baseline measurement, analysis and intervention must precede each remeasurement; therefore, the factor requires two full cycles of measurement, analysis and intervention, followed by one additional remeasurement and analysis.

Exceptions

Factors 5 and 6 are NA for Initial Surveys.

Related information

Where there are barriers to access and availability, the organization might expand the number or geographic distribution of network psychiatrists, although network expansion in the absence of a well-documented barrier analysis does not meet the intent of this element.

Pilot programs. Pilot programs are frequently used when testing original interventions that have not been implemented elsewhere, that are complicated or expensive or that respond specifically to the results of the analysis. Pilot programs test such interventions on a smaller segment of the population before extending the action to the entire universe of members affected.

The organization may elect to conduct a pilot program. The pilot population and participating practitioners must be representative of the members in the organization and the delivery system.

Interventions from pilot programs may meet the element if the organization rolls them out, in full form, to the entire member population.

Intermediate measures. Organizations may evaluate effectiveness of an intervention by remeasuring using the same measure specification used for the initial measurement or by conducting an intermediate measurement. An intermediate measure can evaluate process or outcome related to the intervention and can assess if an intervention had a desired effect.

Collaborative activities. Data collection and analysis can occur in the aggregate at the collaborative group level, as appropriate. Sampling should represent participating organizations in the collaborative effort, but does not necessarily need to be stratified for each participating organization. All eligible members from each participating organization should be eligible for the sampling frame.

If the organization is involved in collaborative clinical measurement activities, participating organizations may use a collaborative-level goal or benchmark instead of an organization-specific goal or benchmark to meet this element.

If collaborative-level goals or benchmarks and measurements are based on aggregate data, opportunities for improvement can also be identified at the collaborative level for all participating organizations.

Practitioner-focused interventions can be carried out at the collaborative level.

For member-focused interventions, all eligible members of the participating organization must receive the intervention.

If appropriate, collaborative interventions may be treated as a pilot program. Such pilot interventions meet the element only if they have been rolled out in full form to the entire eligible population.

Measurement of effectiveness may occur in the aggregate at the collaborative group level, as appropriate. Participating organizations may use quantitative measures at the collaborative group level to demonstrate compliance with this standard. The organization must demonstrate the collaborative measure's relevance to its enrolled population.

Alternative scoring. The organization may choose to design QIAs around specific client populations and present more than three QIAs to represent 100% of the member population. If all QIAs fully meet this standard, the organization receives a score of 100%.

If the organization presents more than three QIAs to represent 100% of the member population, and any one of the QIAs does not fully meet this element, NCQA uses the population covered by the QIA to weight the assessment of the standard.

For each QIA assessed, the performance score (measured as percentage of points received) is multiplied by the population percentage and summed to create a weighted average score. Compare the weighted score with the scores in the table below to determine the performance score.

Table 1: Conversion of weighted score to element score

Weighted Score	Element Score
90% or better	100%
At least 80% but <90%	80%
At least 50% but <80%	50%
At least 20% but <50%	20%
<20%	0%

Examples

Clinical QI issues

- Managing ADHD.
- Appropriate outpatient therapy after an inpatient stay.
- Exploring high use of psychotropic medications dispensed by primary care practitioners without a psychiatric consultation.

Clinical HEDIS measures

- *Follow-Up After Hospitalization for Mental Illness (FUH)*: The percentage of members hospitalized for mental illness who received ambulatory follow-up.
- *Antidepressant Medication Management (AMM)*: The percentage of members treated with drugs for depression who remain on medication through an acute and a continuation phase.

Goals vs. benchmarks

- An organization's goal for ambulatory follow-up for members hospitalized for mental illness is 50% and is based on the organization's review of past measurements.
- An organization's benchmark for ambulatory follow-up for members hospitalized for mental illness is 65% and is based on the best performance of organizations nationally.

Qualitative analysis

If the organization wants to improve its rate of ambulatory follow-up for members hospitalized for mental illness, it might determine that any or all of the following are causes of a lower than optimal rate of follow-up:

- A significant number of practitioners are unaware that they must schedule follow-up appointments for all hospitalized patients, or hospitalized patients are unaware of the importance of keeping their follow-up appointments.
- Appointments with network psychiatrists are difficult to schedule or the geographic disbursement of participating practitioners is inappropriate to serve the entire member population.

Strong clinical actions

Based on the potential barriers used in the examples of *Analysis of causes*, the following interventions are targeted specifically at causes of a low rate of ambulatory follow-up for hospitalized patients:

- Where the barrier is practitioners who are unaware that they must schedule follow-up appointments for all hospitalized patients, the organization might initiate targeted, individual communication with each practitioner.

- ~~Where the barrier is patients who are unaware of the importance of ambulatory follow-up, the organization might initiate targeted communication directly with the members.~~

~~**Intermediate measure**~~

~~Organization A's goal is to increase screening rates by encouraging members to schedule a screening appointment. Its intermediate measure of effectiveness is "the percentage of member contacts that resulted in scheduled appointments." The organization will wait to measure the intervention's success at increasing screening until the next annual measurement cycle.~~

~~**Nonspecific actions that do not meet factor 5**~~

- ~~Articles in a member newsletter.~~
- ~~General mailing of clinical practice guidelines without contacting practitioners to ensure their use or integration.~~

~~**Alternative scoring**~~

- ~~Clinical QIA 1 (clients A–C) covers 70% of Mega MBHO's population and demonstrates 100% performance score.~~
- ~~Clinical QIA 2 (client D) covers 20% of Mega MBHO's population and demonstrates 0% performance score.~~
- ~~Clinical QIA 3 (client E) covers 10% of Mega MBHO's population and demonstrates 100% performance score.~~

~~(QIA 1's score x QIA 1's population) + (QIA 2's score x QIA 2's population) + (QIA 3's score x QIA 3's population) = performance score~~

~~(100% x 70%) + (0% x 20%) + (100% x 10%) = performance score~~

~~70% + 0% + 10% = 80% = 80% performance score~~

Element A: Performance Measures

At least annually, the organization monitors the following measures:

1. **Follow-Up After Hospitalization for Mental Illness.**
2. ~~**Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment.**~~
3. ~~**Follow-Up Care for Children Prescribed ADHD Medication (Continuation and Maintenance).**~~
4. ~~**Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults.**~~
2. **Adherence to Antipsychotic Medications for Individuals With Schizophrenia.**
3. **Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications.**
4. ~~**Plan All-Cause Readmissions**~~
4. **Follow-Up After Emergency Department Visit for Substance Use**
5. **Follow-Up After High-Intensity Care for Substance Use Disorder**
6. **Follow-Up After Emergency Department Visit for Mental Illness**
7. **Diabetes Monitoring for People With Diabetes and Schizophrenia**
8. **Cardiovascular Monitoring for People With Diabetes and Schizophrenia**
9. **Metabolic Monitoring for Children and Adolescents on Antipsychotics**

10. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Summary of Changes

This element was formerly QI 10, Element C and is now QI 5, Element A

Removed the following measures:

- Initiation and Engagement of Substance Use Disorder Treatment.
- Follow-Up Care for Children Prescribed ADHD Medication (Continuation and Maintenance).
- Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults.
- Plan All Cause Readmission.

Added the following measures:

- Follow-Up After Emergency Department Visit for Substance Use
- Follow-Up After High-Intensity Care for Substance Use Disorder
- Follow-Up After Emergency Department Visit for Mental Illness
- Diabetes Monitoring for People With Diabetes and Schizophrenia
- Cardiovascular Monitoring for People With Diabetes and Schizophrenia
- Metabolic Monitoring for Children and Adolescents on Antipsychotics
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 5-7 factors~~	~~The organization meets 4 factors~~	~~The organization meets 3 factors~~	~~The organization meets 1-2 factors~~	~~The organization meets 0 factors~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Reports

Scope of review

~~NCQA reviews the organization's completed MBHO workbook.~~

For factors 1–9, the organization reports:

- The eligible population.
- The rate.
- Whether HEDIS ~~or Partnership for Quality Measurement (PQM)~~ specifications were followed or were modified to calculate the rates.

~~For measures with multiple indicators (e.g., Follow-Up After Hospitalization for Mental Illness [FUH]), the organization reports all indicators noted in the workbook~~.

Look-back period

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

For Renewal Surveys: 24 months.

Explanation

~~The intent is to move toward an ability to measure and report using standardized specifications that will allow comparisons of performance across organizations.~~

At least annually, the organization assesses its member population by collecting and monitoring performance measures.

Measure specifications may come from HEDIS ~~or PQM,~~ or may be internal to the organization. HEDIS measure specifications may be purchased from NCQA. ~~PQM-endorsed measures can be found on PQM's website. Applicable measure sources are listed below for each measure.~~ NCQA does not require reported results to be audited by an external source.

The organization includes all applicable members in the measure denominator, regardless of where care originated and whether care is provided by a nonbehavioral healthcare practitioner.

Factors 1–10

The organization uses the HEDIS specifications for the following measures. NCQA recognizes that some HEDIS specifications are limited to a specific product line/populations for health plans. The organization may modify them where necessary to make them applicable to their population.

- ~~***Factor 1:*** Follow-Up After Hospitalization for Mental Illness (FUH).~~
- ~~***Factor 2:*** Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET).~~
- ~~***Factor 3:*** Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Continuation and Maintenance.~~
- ~~***Factor 5:*** Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA).~~
- ~~***Factor 6:*** Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD).~~

~~***Factor 4:*** **Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults**~~

~~The organization bases the measure calculation on HEDIS measure Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E) or the PQM-endorsed measure (Depression Assessment with PHQ-9/ PHQ-9M). The measures assess use of the PHQ-9 for monitoring treatment progress in members with diagnosed depression.~~

~~***Factor 7:*** **Plan All-Cause Readmissions**~~

~~The organization may use the HEDIS Plan All-Cause Readmissions (PCR) measure or submit an internally developed measure produced as part of ongoing monitoring activities. If an internally developed measure is used, the organization describes the data collection methods it used, including:~~

- ~~The numerator and denominator.~~
- ~~Data sources (e.g., from claims, electronic medical records).~~
- ~~Data collection and sampling techniques, if sampling was used.~~

Reporting. For all measures, the organization:

- Reports at the organization level (not by product line).
- Includes all eligible members in the measure denominator, regardless of where care originated.
  - For example, if a primary care practitioner initiated care, the organization

determines if the member received appropriate follow-up care and should be included in the measure denominator.

- Uses data from its databases and records to calculate rates.
- May supplement information with data received from health plan clients to calculate rates.

For measures requiring the use of HEDIS technical specifications, the organization:

- May modify the specifications to calculate rates across product lines and to make measures applicable to an MBHO.
  - For example, an organization with 80% enrollment in Medicaid may use the Medicaid continuous enrollment criteria in the HEDIS technical specifications when selecting the eligible population.
  - An organization may modify the specifications for measures that require follow-up with a primary care practitioner, allowing follow-up with a behavioral healthcare practitioner.
- Uses the technical specifications appropriate to the reporting year.
  - For example, an organization undergoing survey in the 2025 standards year uses the HEDIS measurement year (MY) 2024 technical specifications. Results are not required to be audited by an external source.

~~*For factor 4:* The organization uses the e-measure specifications to calculate results for this measure and may include only patients being managed by behavioral healthcare practitioners. Numerator events are included in the medical/behavioral health record; however, the organization may use information from supplemental databases (e.g., registries) if the information is returned to the treating behavioral healthcare practitioner.~~

~~*For factor 7:*~~ If HEDIS technical specifications are used, the organization reports:

- ~~The count of index stays (denominator).~~
- ~~The count of 30-day readmissions (numerator).~~
- ~~Whether HEDIS specifications were followed or were modified to calculate the rate.~~

~~If the organization's internal specifications are used, the organization:~~

- ~~Records the denominator in the "Count of Index Stays" cell and records the numerator in the "Count of 30-Day Readmissions" cell.~~
- ~~Notes that HEDIS specifications were not followed or were modified to calculate the rate.~~
- ~~Describes the denominator and the numerator.~~
- ~~Lists data sources (e.g., claims, electronic medical records).~~
- ~~Summarizes data collection and sampling techniques (if sampling was used).~~

No eligible population. The organization explains measures with a denominator of zero (i.e., no eligible population).

There are no "NA" responses for this element. A factor is not met if the organization cannot identify the eligible population because it does not receive data from the health plan client.

The organization is eligible to receive credit for factors with a denominator of zero if no members met the criteria for inclusion in the denominator during the measurement year.

Exceptions

None.

QI 11: Effectiveness of the QI Program

The organization demonstrates improvements in the clinical care and service it renders to members.

Intent

The organization measures the quality of members' care and service and demonstrates improvements that positively affect the care and service members receive.

Element A: Meaningful Clinical Improvements

The organization demonstrates meaningful improvements in the following:

1. **An area of clinical care.**
2. **A second area of clinical care.**

Summary of Changes

-

Scoring

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

Data source Reports

Scope of review *For Renewal Surveys:* NCQA reviews up to six quality improvement activities (QIA) that measure the effectiveness of two areas of clinical care.

Look-back period *For Renewal Surveys:* NCQA evaluates from the baseline period up to the current year.

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.

QIAs includes all populations from all products and product lines to be considered for review. If the organization excludes a population, it states its strong rationale for doing so. NCQA reviews the rationale to determine if it is appropriate.

Requirements for meaningful improvement

Meaningful or significant improvement is the result of an activity that meets all the following criteria:

- Has occurred.
- Is relevant to the organization's population.
- Affects a significant portion of the population or a high-risk population.
- Is likely to result in better outcomes for the population.
- Is attributable to the strength, duration and quality of the organization's actions and not to confounders, such as chance.
- Is supported by valid study design and by quantitative and qualitative analyses.
- Is sustained over time.

NCQA does not consider achieving a prespecified goal or benchmark to be a

demonstration of improvement.

NCQA reviews QIAs to validate meaningful improvement. The organization provides documentation of its QIAs that demonstrates:

- The activity's relevance.
- Valid methodology.
- Quantitative and qualitative analysis of results.
- Barrier analysis.
- Determination of opportunities for improvement.
- Strong, timely interventions.
- Significant improvement (statistical significance is not required).

Methodology

NCQA evaluates the following aspects of QIA design:

- A defined numerator and denominator.
- The sampling approach used.
- The sample size calculation.
- Measurement periods and seasonality effects.
- Appropriateness of the statistical test, if applicable (statistical significance not required).
- The impact on the organization's population.

If the activity includes a survey, NCQA evaluates the following protocol items:

- Who administered the survey.
- To whom the survey was administered.
- How the survey was administered.
- How the survey's validity was established.
- How the results were analyzed.
- The definition of a "complete" survey.
- The expected and achieved response rate.

Period of measurement

QIAs include at least two measurements, a baseline measure and a comparison measure. The two measurements must be at least 1 year apart during the activity period. The organization provides documentation that the QIA demonstrated improvement within the 3-year Accreditation period being evaluated.

The baseline measure may have occurred as the last measurement in the previous Accreditation period or during the current Accreditation period, but to meet the requirement, all remeasurements must occur within the 3 years immediately prior to the Accreditation Survey. The last measurement must show improvement from the baseline.

If applicable, to avoid seasonality concerns, the QIA design includes one of the following:

- Annual measurement occurring during the same season, for areas that show seasonal differences.
- Five quarters of data.
- Fifteen months of data.

NCQA also counts longitudinal studies (measurement of the same set of members each time) and use of multiple measurements (e.g., quarterly or monthly), as long as the organization uses appropriate statistical tests.

Exception

This element is NA for Initial Surveys.

Related information

Multiclient activities. Aggregate measurements at the multiclient level that demonstrate meaningful improvement may be used by all involved organizations to show performance against this element, as appropriate.

Involved client organizations must demonstrate that the improvement was meaningful, as described above.

A multiclient activity may be considered as a pilot program, if applicable. If a pilot program shows meaningful improvement and has been rolled out to the organization's entire population (as demonstrated by letters to practitioners announcing expansion and detailed work plans, for example), it may be considered as one quality improvement activity. Only one pilot activity may be used for QI 11, Element A.

Collaborative activities. NCQA encourages organizations to collaborate on QIAs, especially where multiple organizations have overlapping provider and practitioner networks. NCQA reviews collaborative QIAs using the same criteria it uses to review individually executed QIAs.

The organization may submit a collaboratively prepared QIA that includes the following:

- All organizations involved in sponsoring the activity.
- The relevance of the activity to the individual organization's members.
- The number of members affected, in the individual organization and in total.
- The impact on the individual organization's existing delivery system.
- Other requirements of the QIA instructions and form.

This activity meets the intent of this element if results show meaningful improvement. Aggregate measurements at the collaborative group level showing meaningful improvement can be used by all of the participating organizations, as appropriate.

Pilot programs. A pilot activity showing meaningful improvement may count as *one improvement only,* and it must meet all of the following criteria:

- The magnitude of the improvement is statistically significant for the pilot population.
- The pilot population and participating practitioners are representative of the members in the organization and the delivery system.
- The full intervention has been rolled out to the entire eligible population, although there may not have been remeasurement.

Alternative scoring. The organization may choose to design QIAs around specific client populations and present more than two clinical QIAs to represent 100% of the member population. If all QIAs fully meet Element A, the organization receives a compliance designation of 100%.

If the organization presents more than two clinical QIAs to represent 100% of the member population, and any one of the QIAs does not demonstrate meaningful

improvement, NCQA uses the population covered by the QIA to weight the assessment of the element.

For each QIA assessed, the performance score (measured as percentage of points received) is multiplied by the population percentage and summed to create a weighted average score. Compare the weighted score with the scores in the table below to determine the performance score.

Table 1: Conversion of weighted score to element score

Weighted Score	Element Score
90% or better	100%
At least 80% but <90%	80%
At least 50% but <80%	50%
At least 20% but <50%	20%
<20%	0%

Use of length-of-stay measurements. In general, QIAs that only include measurements of length of stay or appropriateness of stay or appropriateness of location are not suitable for QI 11, Element A; however, if the organization can demonstrate a direct link between the activities and improvements in clinical outcomes, quality of life indicators or clinical process guidelines, NCQA considers them.

For example, NCQA does not consider for QI 11, Element A an activity that only demonstrates a reduction in length of stay for chemical dependency/abuse admissions. NCQA considers the activity if the organization also provides evidence of improved quality of life as a result of interventions.

Examples

Clinical activities

Follow-Up After Hospitalization for Mental Illness (FUH)

- The percentage of individuals 6 years of age and older seen for an ambulatory follow-up visit within 7 or 30 days after discharge.

Adequacy of Clinical Management for Major Depressive Disorder

- The percentage of individuals prescribed antidepressants for major depressive disorder with at least three follow-up contacts with appropriate practitioners.

Strong clinical actions

Follow-Up After Hospitalization for Mental Illness (FUH)

- Design and implement patient and practitioner education on the importance of follow-up.
- Implement procedure of scheduling follow-up visits before discharge.
- Implement case manager reminder calls to patients after discharge.

Adequacy of Clinical Management for Major Depressive Disorder

- Mail clinical practice guidelines for major depressive disorder to network practitioners and initiate individual communication with practitioners to ensure their use or integration.
- Initiate targeted, individual communication with members to provide them with educational information outlining the importance of keeping follow-up appointments.
- Distribute monthly reminders to practitioners of patients prescribed

antidepressants who have not had follow-up visits.

Meaningful improvement

Clinical improvement

- Reduced rates of acute episodes of chronic illnesses, improvements in medication compliance.
- Reduced symptoms.
- Increased provision of follow-up care after hospitalization.
- Improved psychosocial functioning.
- Reduced rates of hospitalization for specific disorders.

Each improvement must be related to an intervention designed to effect the change.

Clinical QIAs

Each clinical QIA's meaningful improvement score is multiplied by the percentage of the population covered in that QIA and added to the product of the other clinical QIAs: [(QIA 1 score x population percentage) + (QIA 2 score x population percentage) + (QIA 3 score x population percentage) + (QIA 4 score x population percentage)] = percentage represented in the clinical QIAs = score for element A. The cumulative total cover must equal to 100% to be eligible to receive 100% score for multi-client QIAs.

To determine performance for QI 11, Element A:

Determine the percentage of the enrolled population represented in the clinical QIAs and whether or not it represents meaningful improvement.

(QIA 5's score x QIA 5's % of entire population) + (QIA 6's score x QIA 6's % of entire population) + (QIA 7's score x QIA 7's % of entire population) = Weighted score for the clinical QIAs

(100% x 50% = 50%) + (0% x 20% = 0%) + (100% x 30% = 30%) = 80%

Table 2: Conversion of weighted score to element score

Weighted Score	Element Score
90% or better	100%
At least 80% but <90%	80%
At least 50% but <80%	50%
At least 20% but <50%	20%
<20%	0%

Based on the weighted score (80%), the element score is 80%.

Element B: Meaningful Service Improvements

The organization demonstrates meaningful improvements in the following:

1. **An area of service.**
2. **A second area of service.**

Summary of Changes

-

Scoring

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

Data source Reports

Scope of review *For Renewal Surveys,* NCQA reviews QIAs that measure the effectiveness of two areas of service. NCQA evaluates up to four QIAs that the organization presents.

Look-back period *For Renewal Surveys:* NCQA evaluates from the baseline period up to the current year.

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.

To meet the requirements of this element, the organization must demonstrate meaningful improvement in two service activities.

The organization may substitute clinical improvements for service improvements toward this element provided the organization can demonstrate that there are no major service issues that it must address; however, most organizations can identify service opportunities through their member experience data and should use these data to identify opportunities.

NCQA evaluates up to 10 QIAs (including 4 service QIAs) that the organization has prepared for evidence of demonstrated meaningful improvement.

Requirements for meaningful improvement

NCQA reviews QIAs from the organization to validate meaningful improvement. The organization must complete a QIA that demonstrates the following for each potential improvement project:

- The activity's relevance.
- Valid methodology.
- Quantitative and qualitative analysis of results.
- Barrier analysis.
- Determination of opportunities for improvement.
- Strong, timely interventions.
- Significant improvement (statistical significance not required).

NCQA does not consider achieving a prespecified goal or benchmark to be a demonstration of improvement.

Methodology

NCQA evaluates the following aspects of QIA design:

- A defined numerator and denominator.
- The sampling approach used.
- The sample size calculation.
- Measurement periods and seasonality effects.
- Appropriateness of the statistical test, if applicable (statistical significance not required).
- The impact on the organization's population.

If the activity includes a survey, NCQA evaluates the following protocol items:

- Who administered the survey.

- The surveyed population.
- How the survey was administered.
- How the survey's validity was established.
- How the results were analyzed.
- The definition of a completed survey.
- The expected and achieved response rate.

Period of measurement

QIAs include at least two measurements, a baseline measure and a comparison measure. The two measurements must be at least 1 year apart during the activity period. The organization provides documentation that the QIA demonstrated improvement within the 3-year Accreditation period being evaluated.

The baseline measure may have occurred as the last measurement in the previous Accreditation period or during the current Accreditation period, but to meet the requirement, all remeasurements must occur within the 3 years immediately prior to the Accreditation Survey. The last measurement must show improvement from the baseline.

If applicable, to avoid seasonality concerns, the study design should include one of the following:

- Annual measurement occurring during the same season, for areas that show seasonal differences.
- Five quarters of data.
- Fifteen months of data.

NCQA also counts longitudinal studies (measurement of the same set of members each time) and use of multiple measurements (e.g., quarterly or monthly), as long as the organization uses appropriate statistical tests.

Exception

This element is NA for Initial Surveys.

Related information

Multiclient activities. Aggregate measurements at the multiclient level that demonstrate meaningful improvement may be used by all involved organizations to show performance against this element, as appropriate.

Involved client organizations must demonstrate that the improvement was meaningful, as described above.

A multiclient activity may be considered as a pilot program, if applicable. If a pilot program shows meaningful improvement and has been rolled out to the organization's entire population (as demonstrated by letters to practitioners announcing expansion and detailed work plans, for example), it may be considered as one quality improvement activity. Only one pilot activity may be used for QI 11, Element B.

Collaborative activities. NCQA encourages organizations to collaborate on QIAs, especially where multiple organizations have overlapping provider and practitioner networks. NCQA reviews collaborative QIAs using the same criteria it uses to review individually executed QIAs.

The organization may submit a collaboratively prepared QIA that includes the following:

- All organizations involved in sponsoring the activity.
- The relevance of the activity to the organization's members.
- The number of members affected, in the organization and in total.
- The impact on the organization's existing delivery system.
- Other requirements of the QIA instructions and form.

NCQA counts the activity toward meeting this element if the results of the activity show meaningful improvement. Aggregate measurements at the collaborative group level showing meaningful improvement can be used by all of the participating organizations, as appropriate.

Pilot programs. A pilot activity showing meaningful improvement counts as *one improvement only* and meets all of the following criteria:

- The magnitude of the improvement is statistically significant for the pilot population.
- The pilot population and participating practitioners are representative of the members in the organization and the delivery system.
- The full intervention has been rolled out to the entire eligible population, although there may not have been remeasurement.

Alternative scoring. The organization may choose to design QIAs around specific client populations and present more than two service QIAs to represent 100% of the member population. If all QIAs fully meet Element B, the organization receives a compliance designation of 100%.

If the organization presents more than two service QIAs to represent 100% of the member population, and any one of the QIAs does not demonstrate meaningful improvement, NCQA uses the population covered by the QIA to weight the assessment of the element.

For each QIA assessed, the performance score (measured as percentage of points received) is multiplied by the population percentage and summed to create a weighted average score. Compare the weighted score with the score in the table below to determine the performance score.

Table 1: Conversion of weighted score to element score

Weighted Score	Element Score
90% or better	100%
At least 80% but <90%	80%
At least 50% but <80%	50%
At least 20% but <50%	20%
<20%	0%

Examples

Service activities

Low practitioner availability in certain geographic areas

- Complaint rates on practitioner availability.
- GeoAccess maps showing that the number of practitioners is lower than the organization's goals in some geographic areas.

High call abandonment rate

- A call abandonment rate in customer service higher than the organization's goal.

Claims processing

- Improve claims timeliness exceeding the organization's goals.
- Reduce the high percentage of claims resubmitted to the organization for payment.

Strong service actions

Low availability of practitioners in certain areas

- Increase recruitment efforts in specific areas, demonstrated by numbers of practitioners contacted and credentialed.

High call abandonment rate

- Increase staff in customer service.
- Intensify training.
- Route calls more appropriately.

Claims processing

- Identify and correct inefficiencies in the claims payment process.

Meaningful improvement

Service improvements

- Improved access to telephone lines.
- Decreased processing time for appeals.
- Improved member experience in specific areas.Improved member experience in specific areas.
- Decreased member complaints for specific reasons.
- Decreased the claims processing turnaround time.
- Higher percentage of members report that they have no problem finding a practitioner.

Each improvement must be related to an intervention designed to effect the change.

~~*Service QIAs*~~

~~Each service QIAs meaningful improvement score is multiplied by the population covered in that QIA and added to the product of the other service QIAs:~~

~~[(QIA 1 score x population percentage) + (QIA 2 score x population percentage) + (QIA 3 score x population percentage) + (QIA 4 score x population percentage)] = percentage represented the service QIAs = score of QI 11, Element B.~~

~~*Example:*~~

~~Determine the percentage of the enrolled population represented in the service QIAs and whether or not it represents meaningful improvement.~~

~~(QIA 8's score x QIA 8's population) + (QIA 9's score x QIA 9's population) = percentage for the service QIAs~~

~~(0% x 30% = 0%) + (100% x 30% = 30%) + (100% x 40% = 40%) = 70% = service percentage for the service QIAs = 50% for Element B~~

QI 6 ~~12~~: Delegation of QI

If the organization delegates any NCQA-required QI activities, there is evidence of oversight of the delegated activity.

Intent

The organization remains responsible for and has appropriate structures and mechanisms to oversee delegated QI activities.

Element A: Delegation Agreement

The written delegation agreement:

1. **Is mutually agreed upon.**
2. **Describes the delegated activities and the responsibilities of the organization and the delegated entity.**
3. **Requires at least semiannual reporting by the delegated entity to the organization.**
4. **Describes the process by which the organization evaluates the delegated entity's performance.**
5. **Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.**

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 5 factors~~	~~The organization meets 4 factors~~	~~The organization meets 3 factors~~	~~The organization meets 1-2 factors~~	~~The organization meets 0 factors~~

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

Data source Materials

Scope of review NCQA reviews delegation agreements in effect during the look-back period from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

The score for the element is the average of the scores for all delegates.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 24 months.

Explanation This element may not be delegated.

This element applies to agreements that are in effect within the look-back period.

The delegation agreement describes of all delegated QI activities. A generic policy statement about the content of delegated arrangements does not meet this element.

Factor 1: **Mutual agreement**

Delegation activities are mutually agreed on before delegation begins, in a dated, binding document or communication between the organization and the delegated entity.

NCQA considers the effective date specified in the delegation agreement as the mutually agreed-upon effective date. The effective date may be before or after the signature date on the agreement. If the agreement has no effective date, NCQA considers the signature date (meaning the date of last signature) as the mutually agreed upon effective date.

NCQA may accept other evidence of the mutually agreed-upon effective date: a letter, meeting minutes or other form of communication between the organization and the delegate that references the parties' agreement on the effective date of delegated activities.

NCQA requires submitted evidence for all other delegation factors to consider the same mutually agreed-upon date as the effective date for the delegate's performance of delegated activities.

Factor 2: **Assigning responsibilities**

The delegation agreement or an addendum thereto or other binding communication between the organization and the delegate specifies the QI activities:

- Performed by the delegate in detailed language.
- Not delegated, but retained by the organization.
  - The organization may include a general statement in the agreement addressing retained functions (e.g., the organization retains all other QI functions not specified in this agreement as the delegate's responsibility).

If the delegate subdelegates an activity, the delegation agreement must specify which organization is responsible for oversight of the subdelegate.

Factor 3: **Reporting**

The organization determines the method of reporting and the content of the reports, but the agreement must specify:

- That reporting is at least semiannual.
- What information is reported by the delegate about QI delegated activities.
- How, and to whom, information is reported (i.e., joint meetings or to appropriate committees or individuals in the organization).

The organization must receive regular reports from all delegates, even NCQA-Accredited or NCQA-Certified delegates.

Factor 4: **Performance monitoring**

The delegation agreement specifies how the organization evaluates the delegate's performance.

Factor 5: **Consequences for failure to perform**

The delegation agreement specifies consequences if a delegate fails to meet the terms of the agreement and, at a minimum, circumstances that would cause revocation of the agreement.

Exception

This element is NA if the organization does not delegate QI activities.

Examples None.

Element B: Predelegation Evaluation

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization evaluated delegate capacity before delegation began~~	~~No scoring option~~	~~The organization evaluated delegate capacity after delegation began~~	~~No scoring option~~	~~The organization did not evaluate delegate capacity~~

Met	Partially Met	Not Met
Met	**Partially Met**	**Not met**
The organization evaluated delegate capacity before delegation began	The organization evaluated delegate capacity after delegation began	The organization did not evaluate delegate capacity

Data source Reports

Scope of review *This element applies if delegation was implemented in the look-back period.*

NCQA reviews the organization's predelegation evaluation of up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

The score for the element is the average of the scores for all delegates.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 12 months.

Explanation This element may not be delegated.

NCQA-Accredited/Certified delegates

Automatic credit is available for this element if all delegates are NCQA-Accredited health plans, MBHOs or Case Management Organizations, NCQA-Accredited or NCQA-Certified DM Organizations, NCQA-Accredited PHP Organizations or NCQA-Prevalidated Health IT Solutions, unless the element is NA.

Note: *For organizations that have both NCQA-Accredited/Certified and non-Accredited/Certified delegates:*

- *NCQA-Accredited/Certified delegates are eligible for automatic credit.*
- *Non-Accredited/Certified delegates are reviewed and scored accordingly.*

Predelegation evaluation

The organization evaluated the delegate's capacity to meet NCQA requirements within 12 months prior to implementing delegation. The evaluation may include a review of the organization's structure, processes and staffing in order to determine its capability to perform the delegated function.

NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date.

If the time between the predelegation evaluation and implementation of delegation exceeds the 12 months, the organization conducts another predelegation evaluation.

If the organization amends the delegation agreement to include additional QI activities within the look-back period, it performs a predelegation evaluation for the additional activities.

Exceptions

This element is NA if:

- The organization does not delegate QI activities.
- Delegation arrangements have been in effect for longer than the look-back period.

Examples

Predelegation evaluation

- Site visit.
- Telephone consultation.
- Documentation review.
- Committee meetings.
- Virtual review.

Element C: Review of the QI Program

For delegation arrangements in effect for 12 months or longer, the organization:

1. **Annually reviews its delegate's QI program.**
2. **Annually audits complex case management files against NCQA standards for each year the delegation has been in effect, if applicable.**
3. **Annually evaluates delegate performance against NCQA standards for delegated activities.**
4. **Semiannually evaluates regular reports, as specified in Element A.**

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 4 factors~~	~~The organization meets 3 factors~~	~~The organization meets 2 factors~~	~~The organization meets 1 factor~~	~~The organization meets 0 factors~~

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 NCQA reviews evidence of the organization's review from up to four randomly selected delegates, or all delegates if the organization has fewer than four.

For All Surveys: NCQA reviews the organization's review of the delegate's QI program (factor 1).

For Initial Surveys: NCQA reviews the organization's most recent annual review, audit, performance evaluation and semiannual evaluation.

For Renewal Surveys: NCQA reviews the organization's most recent and previous year's annual reviews, audits, performance evaluations and four semiannual report evaluations.

The score for the element is the average of the scores for all delegates.

Look-back period *For Initial Surveys:* Once during the prior year.

For Renewal Surveys: 12 months for factor 2; 24 months for all other factors.

Explanation This element may not be delegated.

NCQA-Accredited/Certified delegates

Automatic credit is available for factors 2 and 3 if all delegates are NCQA-Accredited health plans, MBHOs or Case Management Organizations, NCQA-Accredited or NCQA-Certified DM Organizations, unless the element is NA.

Automatic credit is available for factor 3 if all delegates are NCQA-Prevalidated Health IT Solutions or NCQA-Accredited PHP Organizations, unless the element is NA.

Note: *For organizations that have both NCQA-Accredited/Certified and non-Accredited/Certified delegates:*

- *NCQA-Accredited/Certified delegates are eligible for automatic credit.*
- *Non-Accredited/Certified delegates are reviewed and scored accordingly.*

Factor 1: **Review of the QI program**

Appropriate organization staff or committee reviews the delegate's QI program. At a minimum, the organization reviews parts of the QI program that apply to the delegated functions.

Factor 2: **Annual file audit**

If the organization delegates complex case management, it audits the delegate's complex case management files against NCQA standards. The organization uses one of the following to audit the files:

- 5% or 50 files, whichever is less.
- The NCQA "8/30 methodology" available at https://www.ncqa.org/programs/health-plans/policy-accreditation-and-certification/

The organization bases its annual audit on the responsibilities described in the delegation agreement and the appropriate NCQA standards.

Factor 3: **Annual evaluation**

No additional explanation required.

Factor 4: **Evaluation of reports**

No additional explanation required.

Exceptions

This element is NA if:

- The organization does not delegate QI activities.
- Delegation arrangements have been in effect for less than 12 months.

Factor 2 is NA if the organization does not delegate complex case management activities.

Examples None.

Element D: Opportunities for Improvement

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~At least once in each of the past 2 years that the delegation arrangement has been in effect, the organization acted on identified problems, if any~~	~~No scoring option~~	~~The organization took inappropriate or weak action, or acted only in the past year~~	~~No scoring option~~	~~The organization did not act on identified problems~~

Scoring

Met	Partially Met	Not Met
At least once in the each of the past 2 years that the delegation arrangement has been in effect, the organization acted on identified problems, if any	The organization took inappropriate or weak action, or acted only in the past year	The organization did not act on identified problems

Data source Documented process, Reports, Materials

Scope of review NCQA reviews reports for opportunities for improvement, if applicable, from up to four randomly selected delegates, or for all delegates, if the organization has fewer than four delegates, and for evidence that the organization took appropriate action to resolve issues.

For Initial Surveys: NCQA reviews the organization's most recent annual review and follow-up on improvement opportunities.

For Renewal Surveys: NCQA reviews the organization's most recent and previous year's annual review and follow-up on improvement opportunities.

The score for the element is the average of the scores for all delegates.

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

For Renewal Surveys: 24 months.

Explanation This element may not be delegated.

NCQA-Accredited/Certified delegates

Automatic credit is available for this element if all delegates are NCQA-Accredited health plans, MBHOs or Case Management Organizations, NCQA-Accredited or NCQA-Certified DM Organizations, NCQA-Accredited PHP Organizations or NCQA-Prevalidated Health IT Solutions, unless the element is NA.

Note: *For organizations that have both NCQA-Accredited/Certified and non-Accredited/Certified delegates:*

- *NCQA-Accredited/Certified delegates are eligible for automatic credit.*
- *Non-Accredited/Certified delegates are reviewed and scored accordingly.*

Identify and follow up on opportunities

The organization uses information from its predelegation evaluation, ongoing reports or annual evaluation to identify areas of improvement.

Exceptions

This element is NA if:

- The organization does not delegate QI activities.
- Delegation arrangements have been in effect for less than 12 months.
- The organization has no opportunities to improve performance.
  - NCQA evaluates whether this conclusion is reasonable, given assessment results.

Examples None.

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: PHM 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. **Three activities that support practitioners, providers or community-based organizations.**
4. **How member programs are coordinated.**
5. **How members are informed about available PHM programs.**

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

Summary of Changes

- This is a new standard and element in the MBHO product.

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

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 offered in the PHM strategy**

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 about all 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.

Exceptions

None.

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.**

Summary of Changes

- This is a new standard and element in the MBHO product.

Scoring

Met	Partially Met	Not Met
The organization meets 2-3 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.

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. **Behavioral health screening results.**
5. **Electronic health records.**
6. **Health services programs within the organization.**
7. **Advanced data sources.**

Summary of Changes

- This is a new standard and element in the MBHO product.

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:* Behavioral Health Screenings**

The organization demonstrates the capability to integrate data from behavioral health screenings~~.~~

***Factor 5:* Electronic health records**

Integrating EHR data from one practice or provider 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. Behavioral health screening 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.

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 8: 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.

Element B: Population Assessment

The organization annually:

1. Assesses the characteristics and needs, including social determinants of health, of its

member population.

2. **Assesses the needs of child and adolescent members.**
3. **Assesses the needs of members with disabilities.**
4. **Assesses the needs of members with serious mental illness or serious emotional disturbance.**
5. **Assesses the needs of members of racial or ethnic groups.**
6. **Assesses the needs of members with limited English proficiency.**
7. **Identifies and assesses the needs of relevant member subpopulations.**

Summary of Changes

- This is a new standard and element in the MBHO product.

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

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 policies and procedures.

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

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

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

Annually, the organization uses data at its disposal (e.g., claims, encounters, lab, pharmacy, utilization management, socioeconomic data, demographics) to identify the needs of its population.

***Factor 1:* Characteristics and needs**

To determine the necessary structure and resources for its PHM program, the organization's assessment includes social determinants of health (SDOH) and other population characteristics.

Social determinants of health[1] are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks. The organization defines the determinants assessed.

***Factor 2:* Needs of children and adolescents**

[1] https://health.gov/healthypeople/objectives-and-data/social-determinants-health

The organization assesses the needs of members 2–19 years of age (children and adolescents). If the organization's regulatory agency's definition of children and adolescents is different from NCQA's, the organization uses the regulatory agency's definition. The organization provides the definition to NCQA, which determines whether the organization's needs assessment is consistent with the definition.

Factors 3, 4: **Individuals with disabilities, serious mental illness or serious emotional disturbance**

The organization assesses the needs of members with disabilities in factor 3, and assesses the needs of members with serious mental illness (SMI) or serious emotional disturbance (SED) in factor 4. These members have particularly acute needs for care coordination, and intense resource use (e.g., prevalence of chronic diseases).

Factors 5: **Members of racial or ethnic groups**

The organization may use direct or indirect data collection to assess the racial or and ethnic needs groups of its population. The organization may collect data directly, at various points of interaction with members, or indirectly, from third-party sources. The organization describes needs that may be relevant or specific to member experiences or cultures from identified racial or ethnic groups.

Note: *NET 1: Availability of Practitioners, Element A, is specific to member needs relative to the organization's network. This assessment may be used in PHM 2, Element B, factor 5, but the organization must also go beyond to evaluate member needs in general, not only those specific to the network.*

Factor 6: **Assess the needs of members with limited English proficiency**

The organization assesses and describes the needs of its members with limited English proficiency. To assess limited English proficiency, the organization must first collect data on its population's language profile. The organization may use direct or indirect data collection to determine the languages spoken by its members. The organization then utilizes the data to determine the needs of members whose primary language is a language other than English.

Factor 7: **Identifying and assessing characteristics and needs of subpopulations**

A **subpopulation** is a group of individuals within the membership who share characteristics. The organization uses its assessment of the member population (factor 1) to identify and assess the characteristics and needs of relevant subpopulations. The organization includes at least two relevant subpopulations in its assessment, and considers at least two characteristics or needs for each. The subpopulations identified in factor 7 must be different from those outlined in factors 2–6. The organization's assessment describes how it determined that the subpopulation is relevant to its membership as a whole.

Exception

Factor 2 is NA for the Medicare product line.

Related information

A vendor relationship exists if the organization contracts with a NCQA-Prevalidated Health IT Solution to perform assessments. The organization must demonstrate that the assessment is conducted annually.

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 8: Delegation of PHM*. NCQA evaluates the vendor's documentation against the requirements. Refer to *Vendors in Appendix 2: Delegation and Automatic Credit Guidelines.*

Examples

Factors 1, 7: **Relevant characteristics**

Social determinants of health include, but are not limited to:

- Resources to meet daily needs.
- Safe housing.
- Local food markets.
- Access to educational, economic and job opportunities.
- Access to health care services.
- Quality of education and job training.
- Availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities.
- Transportation options.
- Public safety.
- Social support.
- Social norms and attitudes (e.g., discrimination, racism, and distrust of government).
- Exposure to crime, violence and social disorder (e.g., presence of trash and lack of cooperation in a community).
- Socioeconomic conditions.
- Residential segregation.
- Language/literacy.
- Access to mass media and emerging technologies.
- Culture.

Other characteristics:

- Natural environment, such as green space (e.g., trees and grass) or weather (e.g., climate change).
- Built environment, such as buildings, sidewalks, bike lanes and roads.
- Worksites, schools and recreational settings.
- Housing and community design.
- Exposure to toxic substances and other physical hazards.
- Physical barriers, especially for people with disabilities.
- Aesthetic elements (e.g., good lighting, trees, benches).
- Multiple chronic conditions or severe injuries.
- Eligibility categories included in Medicaid managed care (e.g., TANF, low-income, SSI, other disabled).
- Nature and extent of carved out benefits.
- Types of Special Needs Plan (SNP) (e.g., dual eligible, institutional, chronic).
- Age.
- Race.
- Ethnicity.

- Language preference.

***Factor 3:* Individuals with disabilities**

Disabilities may include, but are not limited to:

- Vision or hearing loss.
- Ambulatory status.
- Partial or total loss of the use of limbs (quadriplegia, paraplegia).
- Back injury.
- Immune system disorder (e.g., HIV/AIDS, lupus, rheumatoid arthritis).
- Neurological disorder (e.g., multiple sclerosis, cerebral palsy, Parkinson's disease, epilepsy).
- Intellectual and developmental disabilities.

***Factor 5:* Assessment of race, ethnicity**

Direct data collection sources:

- Enrollment forms, when not prohibited by state law.
- Complex case management intake forms.
- Member surveys or focus groups.

Indirect data collection sources:

- U.S. Census data on the racial/ethnic composition of the population.
- Published health statistics, health services research, data provided by plan sponsors or government agencies.
- Estimation methods such as:
- *Geocoding:* Using an individual's home address to infer other information, including race/ethnicity.
- *Surname analysis:* Using an individual's last name to infer other information, including race/ethnicity.

***Factor 6:* Assess the needs of members with limited English proficiency**

Direct data collection sources:

- Member surveys and focus groups.
- Usage of translation services by Member Services as an indicator of member language preference.

Indirect data collection sources:

- State-level census or community-level data.
- The Modern Language Association Language Map (http://www.mla.org/map_main).

Population language profile:

- 65% of members speak English as their primary language, 25% speak Spanish and 10% speak Mandarin.

Element C: Activities and Resources

The organization annually uses the population assessment to:

1. **Review and update its PHM activities to address member needs.**
2. **Review and update its PHM resources to address member needs.**
3. **Review and update activities or resources to address health care disparities for at least one identified population.**
4. **Review community resources for integration into program offerings to address member needs.**

Summary of Changes

- This is a new standard and element to the MBHO product.

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 Interim Surveys, First Surveys and Renewal Surveys for all product lines.

Documentation

For Interim Surveys: NCQA reviews the organization's policies and procedures.

For First and Renewal Surveys: NCQA reviews committee minutes or similar documents showing process and resource review and updates.

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

***Factors 1, 2:* PHM activities and resources**

The organization uses assessment results to review and update its PHM strategy, including programs, services, activities and resources to meet member needs. Updates are based on assessment of populations identified in PHM 2, Element B. The organization describes the populations and needs it addresses.

***Factor 3:* Address health care disparities for identified population**

The organization uses assessment results to identify health care disparities among members of racial or ethnic minority groups and members with limited English proficiency.

The organization reviews and updates its programs, services, activities or resources to address disparities identified in PHM 2, Element B, factors 5 and 6. The organization reviews and updates at least one program, service, activity or resource, as needed, in response to at least one discovered disparity.

***Factor 4:* Community resources**

The organization connects members with community resources or promotes community programs. Integrating community resources indicates that the organization actively and appropriately responds to members' needs. Community resources correlate with member needs discovered during the population

assessment.

Actively responding to member needs is more than posting a list of resources on the organization's website; active response includes referral services and helping members access community resources.

Exceptions

None.

~~None.~~

~~Examples~~

Element D: Segmentation

At least annually, the organization segments or stratifies its entire population into subsets for targeted intervention.

1. Segments or stratifies its entire population into subsets for targeted intervention.

Summary of Changes

- This is a new standard and element to the MBHO product.

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

Scope of review

Product lines

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

Documentation

For factor 1, NCQA reviews a description of the methods used to segment or stratify the organization's membership, including subsets to which members may be assigned.

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

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

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

Population segmentation is the process of dividing a population into meaningful subsets—members who share specific needs, characteristics, identities, conditions or behaviors—using information collected through population assessments and other data sources.

Risk stratification refers to a subset of population segmentation methods and is the process of dividing a population into groups or categories based on potential risk (e.g., poor health outcomes, high utilization or expense), and then assigning individuals to specific risk tiers or subsets.

Segmentation and risk stratification categorize individuals with care needs at all levels and intensities and may use findings from population assessments and data integration (e.g., clinical and behavioral data, population and social needs) to target resources and interventions (e.g., program access, eligibility for specific services or treatments) to individuals who can most benefit from them.

Factor 1: **Segment or stratify entire population**

Methodology. The organization describes its method for segmenting or stratifying its membership, including the subsets to which members are assigned. Either process may be used to meet this element. The organization may use more than one method to determine actionable subsets.

Although the organization's methods may include utilization/resource use or cost information (e.g., claims data, encounter data), segmentation or stratification methods that focus exclusively on this information do not meet the intent of this element, due to their potential to exacerbate health inequities.

Reports. The organization provides reports specifying the number of members in each category and the programs or services for which they are eligible. Reports are a "point-in-time" snapshot during the look-back period.

Reports reflect the number of members eligible for each PHM program. They display data in raw numbers and as a percentage of the total enrolled member population. The percentage may total more than 100% if members fall into more than one category.

PHM programs or services provided to members include, but are not limited to, complex case management.

Exceptions

None.

Related information

A vendor relationship exists if the organization contracts with a NCQA-Prevalidated Health IT Solution to perform these functions. If an NCQA-Prevalidated vendor supports this function, the organization must demonstrate that the segmentation or stratification is conducted annually.

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 8 Delegation of PHM*. NCQA evaluates the vendor's documentation against the requirements. Refer to *Vendors in Appendix 2: Delegation and Automatic Credit Guidelines.*

PHM 3: Delivery System Supports

The organization describes how it supports the delivery system use of value-based payment arrangements.

Intent

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

Element A: Practitioner or Provider Support

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

1. **Sharing data.**
2. **Providing practice transformation support to behavioral health care practitioners.**

Summary of Changes

- This is a new standard and element to the MBHO product.

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 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.

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 practitioners and providers in meeting population health goals. 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 2: **Practice transformation support**

Transformation includes movement to becoming a more-integrated or advanced practice toward value-based care delivery.

The organization provides documentation that it supports practice transformation. Organizations may offer learning collaboratives, continuing education, and other

methods.

Exceptions

None.

Related information

Partners in Quality. The organization receives automatic credit for factor 2 if it is an NCQA-designated Partner in Quality.

The organization must provide documentation of its status.

Practice transformation support. The organization can support its practitioners or providers in meeting their population health management goals through any of the following methods:

- Technology support.
- Best practices.
- Supportive educational information, including webinars or other education sessions.

Element B: Value-Based Payment Arrangements

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

Summary of Changes

- This is a new standard and element to the MBHO product.

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 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, sourced from *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.

- *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 payments for supplemental services also fall under this payment approach.
- *Shared savings*: Payments are FFS, but provider/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*: Payments are FFS, but providers/practitioners agree to share cost overruns in exchange for the opportunity to receive shared savings.
- *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.

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.

PHM 4: Behavioral Health Screening (former QI 6)

The organization establishes behavioral health screening programs based on evidence and distributes program information to practitioners and providers.

Intent

The organization ensures that each of the behavioral health screening programs has a program description, is based on evidence and that practitioners and providers are informed about the availability of the programs.

Element A: Screening Programs

The organization implemented:

1. **A screening program that addresses coexisting mental health and substance use disorders.**
2. **A second screening program.**

Summary of Changes

- This element was formerly QI 6, Element A.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 2 factors~~	~~No scoring option~~	~~The organization meets 1 factor~~	~~No scoring option~~	~~The organization meets 0 factors~~

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

Data source	Documented process, Materials
Scope of review	NCQA reviews the organization's policies and procedures and documentation of implementation of two behavioral health screening programs, one of which addresses coexisting mental health and substance use disorders.
Look-back period	*For Initial Surveys:* 6 months. *For Renewal Surveys:* 24 months.
Explanation	Methods for gathering information for screening may include screening

instruments, laboratory tests, clinical reviews and personal contact.

Factor 1: **Implementation of screening program**

The organization implements screening programs to determine the likelihood that a patient has coexisting substance use and mental health disorders or that presenting signs and symptoms may be influenced by co-occurring issues.

Coexisting disorders may include any combination of two or more mental health and substance use disorders identified in the Diagnostic and Statistical Manual of Mental Disorders—V (DSM-V). Patients treated for mental health disorders often misuse substances such as alcohol, nicotine and stimulants.

The organization:

- Screens members who have a mental health disorder, for the presence of a coexisting substance use disorder, *and*
- Screens members who have a substance use disorder, for the presence of a coexisting mental health disorder.

Factor 2: **Implementation of a second screening program**

No additional explanation required.

Exceptions

None.

Examples

Screening instruments

- Mental Health Screening Form-III (MHSF-III).
- Simple Screening Instrument for Substance Abuse (SSI-SA).
- Addiction Severity Index (ASI).
- The Alcohol Use Disorders Identification Test (AUDIT).
- Beck Depression Inventory-II (BDI-II).
- CAGE Questionnaire.
- Circumstances, Motivation, and Readiness Scales (CMR Scales).
- The Drug Abuse Screening Test (DAST).
- Substance Abuse Treatment Scale.

Secondary screening programs

- Postpartum depression.
- Screening for metabolic syndrome in patients on antipsychotics.
- Depression in patients with significant chronic illness.
- Severe depression.
- Suicide prevention.
- Obsessive compulsive disorder.
- Attention deficit disorder.
- Anxiety disorders.
- Impulse disorders.

Element B: Program Description

For each screening program, the organization documents essential information in a program

description that clearly summarizes the program and explains:

1. **How the organization identifies eligible members.**
2. **Planned screenings and their recommended frequency.**
3. **Conditions where screening is indicated or required.**
4. **How the organization obtains appropriate practitioner input on program design and implementation.**
5. **How the organization obtains appropriate provider input on program design and implementation.**
6. **The organization's process for promoting its screening programs.**

Summary of Changes

- This element was formerly QI 6, Element B.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 6 factors~~	~~The organization meets 4-5 factors~~	~~The organization meets 2-3 factors~~	~~The organization meets 1 factor~~	~~The organization meets 0 factors~~

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

Data source Documented process

Scope of review NCQA reviews the organization's program description.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 24 months.

Explanation This element applies to the programs identified in Element A.

Factor 1: **Identifying eligible members**

The program description summarizes the eligibility criteria for each program and the mechanisms used to identify eligible members.

The organization uses a systematic approach to identify eligible members. Systematic identification is the use of a consistent, rule-based and population-based process to identify all eligible members according to eligibility criteria that the organization has defined for the program.

The organization may identify eligible members among members who have already received behavioral healthcare services, or may identify members from the

overall population.

Factor 2: **Planned screenings and their recommended frequency**

The program description summarizes planned screenings and their recommended frequency based on criteria established by the organization.

Factor 3: **Conditions where screening is indicated or required**

The program description summarizes the specific conditions or circumstances where screening is indicated or required.

Factors 4, 5: **Practitioner and provider involvement and collaborative activities**

The organization explains how it includes appropriate stakeholders' input in program design.

Each stakeholder should have a role in effective implementation of a program and thus should participate in its design.

If the organization collaborates with other organizations to design and implement screening programs, involvement of stakeholders at the collaborative level satisfies this element.

Factor 6: **Promotion**

The organization describes how it promotes its screening programs to its members and practitioners.

Exceptions

None.

Examples

Data used to identify eligible members

Claims.

Treatment records.

Physician referrals.

Diagnosis codes.

Self-referral.

Element C: Programs Based on Scientific Literature

The organization's screening programs are:

1. **Based on reasonable scientific evidence.**
2. **Based on best practices.**
3. **Reviewed and updated every 2 years, or more often if new evidence is available.**

Summary of Changes

- This element was formerly QI 6, Element C.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The~~	~~The~~	~~No scoring~~	~~The~~	~~The~~

~~organization meets 3 factors~~	~~organization meets 2 factors~~	~~option~~	~~organization meets 1 factor~~	~~organization meets 0 factors~~

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

Data source Documented process, Reports, Materials

Scope of review NCQA reviews evidence of the basis for the organization's programs and the updates it makes.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 24 months.

Explanation This element applies to the programs identified in Element A.

***Factor 1:* Scientific basis for screenings**

The organization's screening programs may be adopted from nationally recognized behavioral healthcare organizations that have developed guidelines based on scientific and research literature.

***Factor 2:* Best practices**

In lieu of screening programs based on scientific evidence, the organization may use best practices (i.e., based on industry standards or on expert opinion, with proven reliability).

***Factor 3:* Review and update**

The organization reviews scientific evidence or best practices and updates its programs every 2 years, or more often, if appropriate. Between scheduled biennial reviews, the organization reviews published evidence, if any, before the date of the next biennial review.

Exceptions

Factor 1 is NA if the organization only uses best practices for its screening programs.

Factor 2 is NA if the organization only uses scientific evidence for its screening programs.

Examples

Guideline sources

- American Psychiatric Association.
- National Institutes of Mental Health.
- Healthy People 2030.
- Voluntary health organizations.

Element D: Distribution of Program Information to Practitioners and Providers

The organization distributes behavioral healthcare screening program information to:

1. **Appropriate existing practitioners and providers at least every 2 years and when programs are added or revised.**
2. **New practitioners and providers.**

Summary of Changes

- This element was formerly QI 6, Element D.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 2 factors~~	~~No scoring option~~	~~The organization meets 1 factor~~	~~No scoring option~~	~~The organization meets 0 factors~~

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

Data source Reports, Materials

Scope of review NCQA reviews evidence of distribution of screening information to practitioners and providers.

Look-back period

For Initial Surveys: 6 months.

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.

Distribution of program information

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

Factor 1: **Existing practitioners and providers**

No additional explanation required.

Factor 2: **New practitioners and providers**

NCQA does not prescribe a time frame for sharing materials with new practitioners and providers. If a screening program has a facility-based component, the organization distributes new information about it to all appropriate organization practitioners and providers.

Exceptions

None.

Examples

Typical communication mechanisms

- Practitioner manual.
- Newsletter.
- Treatment-record insert.
- Special mailing.
- Internet.

PHM 5: Self-Management Tools (former QI 7)

The organization has evidence-based self-management tools available to help members manage their health.

Intent

The organization provides self-management tools to help members stay healthy and reduce risk.

Element A: Topics of Tools

The organization offers self-management tools, derived from available evidence, that provide members with information on at least the following wellness and health promotion areas:

1. **Healthy weight (BMI) maintenance.**
2. **Smoking and tobacco use cessation.**
3. **Encouraging physical activity.**
4. **Healthy eating.**
5. **Managing stress.**
6. **Avoiding at-risk drinking.**
7. **Identifying psychiatric symptoms through self-assessment.**
8. **Recovery and resiliency.**
9. **Treatment monitoring.**

Summary of Changes

- This element was formerly QI 7, Element A.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 4 or more factors~~	~~The organization meets 3 factors~~	~~The organization meets 2 factors~~	~~The organization meets 1 factor~~	~~The organization meets 0 factors~~

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, Materials

Scope of review NCQA reviews the organization's policies and procedures for developing evidence based self-management tools, and reviews the organization's self-management tools. Both must be available throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screenshots, supplemented with documentation specifying the required features

and functions of the site. If screenshots provided include detailed explanations of how the site works, the organization is not required to provide supplemental documents.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The organization provides evidence that it can perform all activities required by this element, even if no clients purchase the functions stated in the factors.

Self-management tools

Self-management tools help members determine risk factors, provide guidance on health issues, recommend ways to improve health or support reducing risk or maintaining low risk. They are interactive resources that allow members to enter specific personal information and provide immediate, individual results based on the information. This element addresses self-management tools that members can access directly from the organization's website or through other methods (e.g., printed materials, health coaches).

Evidence-based information

The organization meets the requirement of "evidenced-based" information if recognized sources are cited prominently in self-management tools. If the organization's materials do not cite recognized sources, NCQA also reviews the organization's documented process detailing the sources used, and how they were used in developing the self-management tools.

Factors 1–9

No additional explanation required.

Exceptions

None.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor's self-management tools. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under *QI 12: Delegation of QI*. NCQA evaluates the vendor's self-management tools against the requirements. Refer to *Vendors* in *Appendix 3: Delegation and Automatic Credit Guidelines*.

Examples

Self-management tools

- Interactive quizzes.
- Worksheets that can be personalized.
- Online logs of physical activity.
- Caloric intake diary.
- Mood log.

Recovery and resiliency tools

- Webinar recordings.
- Videos.
- Toolkits.

- Links to other internet resources that offer learning opportunities to help members understand the fundamentals of recovery and resiliency.

Treatment monitoring tools

Downloadable applications for smartphones and other devices aimed at helping members improve well-being through tracking behavior patterns and moods; identifying depression triggers; managing eating disorders; tracking migraines and migraine triggers.

PHM 6: Complex Case Management (former QI 8)

The organization coordinates services for members with complex conditions and helps them access needed resources.

Intent

The organization helps members with multiple or complex conditions to obtain access to care and services, and coordinates their care.

Element A: Population Assessment

The organization annually:

1. **Assesses the characteristics and needs, including social determinants of health, of its member population.**
2. **Assesses the needs of children and adolescents.**
3. **Assesses the needs of individuals with disabilities.**
4. **Assesses the needs of individuals with serious mental illness or serious emotional disturbance.**
5. **Assesses the needs of members of racial or ethnic groups.**
6. **Assesses the needs of members with limited English proficiency.**
7. **Identifies and assesses the needs of relevant member subpopulations.**

Summary of Changes

- This element was formerly QI 8, Element A.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 6-7 factors~~	~~The organization meets 5 factors~~	~~The organization meets 2-4 factors~~	~~The organization meets 1 factor~~	~~The organization meets 0 factors~~

Met	Partially Met	Not Met
The organization meets	The organization meets	The organization meets

5-7 factors	2-4 factors	0-1 factors

Data source Documented process, Reports, Materials

Scope of review NCQA reviews the organization's policies and procedures for factors 1–5.

For Initial Surveys: NCQA also reviews the organization's most recent annual assessment reports.

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

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

For Renewal Surveys: 24 months

Explanation The organization uses data at its disposal (i.e., claims, encounters, lab, pharmacy, utilization management, socioeconomic data, demographics) to identify the needs of its population.

***Factor 1:* Characteristic and needs**

To determine the necessary structure and resources for its complex case management program, the organization's assessment includes social determinants of health and other population characteristics.

Social determinants of health[2] are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks. The organization defines the determinants assessed.

Characteristics that define a relevant population may also include, but are not limited to:

- Federal or state program eligibility (e.g., Medicare or Medicaid, SSI, dual-eligible).
- Multiple chronic conditions or severe injuries.
- At-risk ethnic, language or racial group.

***Factor 2:* Needs of children and adolescents**

The organization assesses the needs of members 2–19 years of age (children and adolescents). If the organization's regulatory agency's definition of children and adolescents is different from NCQA's, the organization uses the regulatory agency's definition. The organization provides the definition to NCQA, which determines whether the organization's needs assessment is consistent with the definition.

***Factors 3, 4:* Individuals with disabilities, serious mental illness or serious emotional disturbance**

The organization assesses the needs of members with disabilities in factor 3, and assesses the needs of members with serious mental illness (SMI) or serious emotional disturbance (SED) in factor 4. These members have particularly acute needs for care coordination and intense resource use (e.g., prevalence of chronic diseases).

***Factor 5:* Members of racial or ethnic groups**

The organization may use direct or indirect data collection to assess the racial or

[2] https://health.gov/healthypeople/priority-areas/social-determinants-health

and ethnic needs groups of its population. The organization may collect data directly at various points of interaction with members or indirectly from third-party sources. The organization describes needs that may be relevant or specific to member experiences or cultures from identified racial or ethnic groups.

Note: QI 3: Availability of Practitioners and Providers, *Element A*, *is specific to member needs relative to the organization's network. This assessment may be used in QI 8, Element A, factor 5, but the organization must go beyond to evaluate member needs in general, not only those specific to the network.*

Factor 6: **Assess the needs of members with limited English proficiency**

The organization assesses the needs of members with limited English proficiency and describes the language needs of this population. To assess limited English proficiency, the organization first collect data on its population's language profile. The organization may use direct or indirect data collection to determine the languages spoken by its members. The organization then utilizes the data to determine the needs of members whose primary language is a language other than English.

Factor 7: **Identifying and assessing characteristics and needs of subpopulations**

A subpopulation is a group of individuals within the membership who share characteristics. The organization uses its assessment of the member population (factor 1) to identify and assess the characteristics and needs of relevant subpopulations. The organization includes at least two relevant subpopulations in its assessment, and considers at least two characteristics or needs for each. The subpopulations identified in factor 7 must be different than those outlined in factors 2–6. The organization's assessment describes how it determined that the subpopulation is relevant to its membership as a whole.

Exceptions

This element is NA if:

- The organization does not perform complex case management activities, *or*
- The organization is not delegated complex case management activities.

Factor 2 is NA for the Medicare product line.

Related information

A vendor relationship exists if the organization contracts with an NCQA-Prevalidated Health IT Solution to perform assessments. The organization must demonstrate that the assessment is conducted annually.

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 ~~*QI 12: Delegation of QI*~~ *PHM 8: Delegation of PHM*. NCQA evaluates the vendor's documentation against the requirements. Refer to *Vendors* in *Delegation and Automatic Credit Guidelines*.

Examples

Factors 1, 7: **Relevant characteristics**

Social determinants of health include, but are not limited to:

- Resources to meet daily needs.
- Safe housing.
- Local food markets.
- Access to educational, economic and job opportunities.

- Access to health care services.
- Quality of education and job training.
- Availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities.
- Transportation options.
- Public safety.
- Social support.
- Social norms and attitudes (e.g., discrimination, racism, and distrust of government).
- Exposure to crime, violence and social disorder (e.g., presence of trash and lack of cooperation in a community).
- Socioeconomic conditions.
- Residential segregation.
- Language/literacy.
- Access to mass media and emerging technologies.
- Culture.

Other characteristics:

- Natural environment, such as green space (e.g., trees and grass) or weather (e.g., climate change).
- Built environment, such as buildings, sidewalks, bike lanes and roads.
- Worksites, schools and recreational settings.
- Housing and community design.
- Exposure to toxic substances and other physical hazards.
- Physical barriers, especially for people with disabilities.
- Aesthetic elements (e.g., sufficient lighting, trees, benches).
- Multiple chronic conditions or severe injuries.
- Eligibility categories included in Medicaid managed care (e.g., TANF, low-income, SSI, other disabled).
- Nature and extent of carved out benefits.
- Type of Special Needs Plan (SNP) (e.g., dual eligible, institutional, chronic).
- Age.
- Race.
- Ethnicity.
- Language preference.

***Factors 3, 4*: Individuals with disabilities**

Disabilities may include, but are not limited to:

- Vision or hearing loss.
- Ambulatory status.
- Partial or total loss of the use of limbs (quadriplegia, paraplegia).
- Back injury.
- Immune system disorder (e.g., HIV/AIDS, lupus, rheumatoid arthritis).
- Neurological disorder (e.g., multiple sclerosis, cerebral palsy, Parkinson's disease, epilepsy).

- Intellectual and developmental disabilities

Factor 5: **Assesses the needs of members of racial or ethnic groups**

- Direct data collection sources:
  - Enrollment forms, when not prohibited by state law.
  - Complex case management intake forms.
  - Member surveys or focus groups.
- Indirect data collection sources:
  - U.S. Census data on the racial/ethnic composition of the population.
  - Published health statistics, health services research, data provided by plan sponsors or government agencies.
- Estimation methods such as:
  - *Geocoding*: Use an individual's home address to infer other information, including race/ethnicity.
  - *Surname analysis*: Use an individual's last name to infer other information, including race/ethnicity.

Factor 6: **Assess the needs of members with limited English proficiency**

- Direct data collection sources:
  - Member surveys and focus groups.
  - Usage of translation services by Member Services as an indicator of member language preference.
- Indirect data collection sources:
  - State-level census or community-level data.
  - The Modern Language Association Language Map (https://www.mla.org/Resources/Guidelines-and-Data/MLA-Language-Map).
- Population language profile (primary language):
  - 65% of members speak English.
  - 25% of members speak Spanish.
  - 10% of members speak Mandarin.

Element B: Activities and Resources

The organization annually uses the population assessment to:

1. Review and update its complex case management activities to address member needs.

2. **Review and update its complex case management resources to address member needs.**
3. **Review and update activities or resources to address health care disparities for at least one identified population.**
4. **Review community resources for integration into program offerings to address member needs.**

Summary of Changes

- This element was formerly QI 8, Element B.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 3-4 factors~~	~~No scoring option~~	~~The organization meets 2 factors~~	~~The organization meets 1 factor~~	~~The organization meets 0 factors~~

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

For Initial Surveys: NCQA reviews the most recent committee minutes or similar documents showing process and resource review and updates.

For Renewal Surveys: NCQA reviews the most recent and previous committee minutes or similar documents showing process and resource review and updates.

Look-back period

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

For Renewal Surveys: 24 months.

Explanation

***Factors 1, 2:* Complex case management activities and resources**
The organization uses assessment results to review and update its complex case management structure, strategy (including programs, services, activities) and resources to meet member needs. Updates are based on assessment of populations identified in QI 8, Element A. The organization describes the populations and needs it addresses.

***Factor 3:* Address health care disparities for identified population**

The organization uses assessment results to identify health care disparities among members of racial or ethnic minority groups and members with limited English proficiency.

The organization reviews and updates its programs, services, activities or resources to address disparities identified in Element A, factors 5 and 6. The organization reviews and updates at least one program, service, activity or resource, as needed, in response to at least one discovered disparity.

***Factor 4:* Community resources**

The organization connects members with community resources or promotes community programs. Integrating community resources indicates that the

organization actively and appropriately responds to members' needs. Community resources correlate with member needs discovered during the population assessment.

Actively responding to member needs is more than posting a list of resources on the organization's website; active response includes referral services and helping members access community resources.

Exception

This element is NA if:

- The organization does not perform complex case management activities, ***or***
- The organization is not delegated complex case management activities.

Examples

Factor 2: **Complex case management resources**

- Staffing ratios.
- Clinical qualifications.
- Job training.
- External resource needs and contacts.
- Cultural competency.

Factor 3: **Address health care disparities for at least one identified population**

- Improve pregnancy outcomes for African American women by providing health diaries for prepartum and postpartum women to track their symptoms.
- Reduce food insecurity to improve maternal health for Hispanic women by partnering with local farmers markets.
- Deliver culturally appropriate interventions for Native American men and women with hypertension.

Factor 4: **Community resources and programs**

- Population assessment determines a high population of elderly members without social supports. The organization partners with the Area Agency on Aging to help with transportation and meal delivery.
- Connect at-risk members with shelters.
- Connect food-insecure members with food security programs or sponsor community gardens.
- Sponsor or set up fresh food markets in communities lacking access to fresh produce.
- Participate as a community partner in healthy community planning.
- Partner with community organizations promoting healthy behavior learning opportunities (e.g., nutritional classes at local supermarkets, free fitness classes).
- Support community improvement activities by attending planning meetings or sponsoring improvement activities and efforts.
- Social workers or other community health workers that contact members to connect them with appropriate community resources.
- Referrals to community resources based on member need.
- Discounts to health clubs or fitness classes.

Element C: Program Description

The description of the organization's complex case management program includes:

1. **Evidence used to develop the program.**
2. **Criteria for identifying patients who are eligible for the program.**
3. **Services offered to members.**
4. **Defined program goals.**
5. **How case management services are integrated with the services of others involved in the member's care.**

Summary of Changes

- This element was formerly QI 8, Element C.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 4-5 factors~~	~~The organization meets 3 factors~~	~~The organization meets 2 factors~~	~~The organization meets 1 factor~~	~~The organization meets 0 factors~~

Met	Partially Met	Not Met
The organization meets 3-5 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data source Documented process

Scope of review NCQA reviews the organization's program description.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 24 months.

Explanation

The overall goal of complex case management is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.

NCQA considers complex case management to be an opt-out program; all eligible members have the right to participate or to decline participate.

The organization offers a variety of programs to its members and does not limit eligibility to one complex condition or to members already enrolled in the organization's disease management program.

Factor 1: **Evidence used to develop the program**

The program description includes the evidence the organization used to develop the complex case management program, which must have been derived from any

of the following:

- Chronic care guidelines from recognized sources.
- Clinical practice guidelines from recognized sources.
- Clinical pathways developed by practitioners in appropriate specialties.
- Scientific evidence from clinical or technical literature or from government research sources.
- Literature reviews (for nonclinical components of the program [e.g., dealing with patient behavior change).

Factor 2: **Eligibility criteria**

The program description states:

- The eligibility criteria for each complex case management program.
  - At a minimum, the criteria must meet NCQA's definition of "complex case management."
- The organization's criteria (process) for proactively identification of eligible members, which may include the use of clinical data sources or predictive modeling software.

Factor 3: **Services**

The program description specifies complex case management services available to eligible members. The organization may provide the services directly or may arrange for services to be provided by other entities or caregivers.

Factor 4: **Program goals**

The program description includes the organization desired level of achievement expressed in explicit measurable objectives and targets for the complex case management program.

Factor 5: **Case management integration**

The program is integrated with other program services necessary to meet member needs.

Exception

This element is NA if:

- The organization does not perform complex case management activities, *or*
- The organization is not delegated complex case management activities.

Examples

Factor 3: **Services**

Typical services may include, but are not limited to:

- Functional capability assessment and monitoring.
- Care coordination, including arranging appointments and referrals to community resources.
- Self-management plan development and adherence monitoring.
- Case management plan development with performance goals.
- Medication reconciliation.

Factor 4: **Program goals**

Program goals may include:

- Improved clinical quality.
- Improved patient experience.
- Reduced costs.

Factor 5: **Case management integration**

Areas of case management program integration may include:

- Disease management.
- Utilization management.
- Wellness programs.
- Health information line.
- Patient-centered medical home.
- Social services.
- Palliative care.

Element D: Identifying Members for Case Management

The organization uses the following sources to identify members for complex case management:

1. **Claim or encounter data.**
2. **Hospital discharge data.**
3. **Pharmacy data, if applicable.**
4. **Data collected through the UM management process, if applicable.**
5. **Data supplied by purchasers, if applicable.**
6. **Data supplied by members or caregivers.**
7. **Data supplied by practitioners.**

Summary of Changes

- The element was formerly QI 8, Element D.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 5-7 factors~~	~~The organization meets 4 factors~~	~~The organization meets 2-3 factors~~	~~The organization meets 1 factor~~	~~The organization meets 0 factors~~

Met	Partially Met	Not Met
The organization meets 4-7 factors	The organization meets 2-3 factors	The organization meets 0-1 factors

Data source Documented process, Reports

Scope of review

NCQA reviews the organization's complex case management policies and procedures.

NCQA also reviews evidence that the organization uses available data throughout the look-back period.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The organization uses the data sources listed to proactively identify members who are eligible for complex case management.

The organization has a process for collecting data, even if it does not currently have access to the data.

Data are generated from existing databases via proactive data mining using programmed reports. Referrals for individual patients do not meet the requirement.

Factors 1–4

No additional explanation required.

***Factor 5:* Purchaser data**

The organization uses assistance category codes or other purchaser-supplied data (e.g., state and federal agencies, employers) to identify members for complex case management.

***Factor 6:* Data supplied by member or caregiver**

The organization uses self-reported data, such as health appraisals (HA), or data provided by a caregiver.

Factor 7: Practitioner data

The organization uses data provided by practitioners, such as electronic health record (EHR) data, if available.

Exception

This element is NA if:

- The organization does not perform complex case management activities, ***or***
- The organization is not delegated complex case management activities.

Related information

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 ~~*QI 12: Delegation of QI.*~~ PHM 8: Delegation of PHM. NCQA evaluates the vendor's documentation against the requirements. Refer to *Vendors* in *Delegation and Automatic Credit Guidelines.*

Examples

***Factors 1, 2:* Claim, encounter or hospital discharge data**

- Data that identify members with conditions that match the eligibility criteria.
- Data that identify members with multiple conditions or who are managed by multiple practitioners or services.

***Factor 3:* Pharmacy data**

- A report of those medications identified as indicating high risk, *or*
- A cumulative cost report for members whose prescriptions exceed the cost threshold.

***Factor 4:* UM data**

- A report from the UM system that identifies members with multiple conditions.
- A report from the UM system that identifies members with multiple hospitalizations or ED visits.

***Factor 5:* Purchaser data**

- Data from medical assistance category codes from state agencies that identify members with conditions or who need services in the organization's eligibility criteria for complex case management.

***Factor 6:* Data supplied by member or caregiver**

- A report that lists all members who responded "yes" to questions flagged on the HA that indicate "complex" status.

***Factor 7:* Practitioner data**

- Data from EHRs identifying members who have multiple conditions and use multiple services.

Element E: Access to Case Management

The organization has multiple avenues for members to be considered for complex case management services, including:

1. **Medical management program referral.**
2. **Discharge planner referral.**
3. **Member or caregiver referral.**
4. **Practitioner referral.**

Summary of Changes

- This element was formerly QI 8, Element E.
- Revised the factor 2 explanation to clarify something.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization~~	~~The organization~~	~~The organization~~	~~The organization~~	~~The organization~~

~~meets 4 factors~~	~~meets 3 factors~~	~~meets 2 factors~~	~~meets 1 factor~~	~~meets 0 factors~~

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 NCQA reviews the organization's policies and procedures.

NCQA also reviews evidence that the organization has multiple referral avenues in place throughout the look-back period and that it communicates the referral options to members (factor 3) and practitioners (factor 4) at least once during the look-back period.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 24 months.

Explanation Multiple referral avenues can minimize the time between identification of a need and delivery of complex case management services.

The organization has a process for facilitating referrals listed in the factors even if it does not currently have access to the source of the referral.

Factor 1: **Medical management program referral**

Medical management program referrals include those that come from programs in other organizations or through a vendor or delegate. These may include disease management programs, UM programs, health information lines or similar programs that can identify needs for complex case management and are managed by organization or vendor staff.

Factor 2: **Discharge planner referral**

~~No additional explanation required.~~ Referrals can come from outpatient or inpatient care unit, or residential facility.

Factors 3, 4: **Member, caregiver, practitioner referrals**

The organization communicates referral options to members (factor 3) and practitioners (factor 4).

Exception

This element is NA if:

- The organization does not perform complex case management activities, ***or***
- The organization is not delegated complex case management activities.

Examples **Facilitating referrals**

- Correspondence from members, caregivers or practitioners about potential eligibility.
- Monthly or quarterly reports, from various sources, of the number of members identified for complex case management.
- Brochures or mailings to referral sources about the complex case management program and instructions for making referrals.

- Web-based materials with information about the complex case management program and instructions for making referrals.

Element F: Case Management Systems

The organization uses case management systems that support:

1. **Evidence-based clinical guidelines or algorithms to conduct assessment and management.**
2. **Automatic documentation of the staff member's ID and date, and time of action on the case or when interaction with the member occurred.**
3. **Automated prompts for follow-up, as required by the case management plan.**

Summary of Changes

- This element was formerly QI 8, Element F.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 2-3 factors~~	~~No scoring option~~	~~The organization meets 1 factor~~	~~No scoring option~~	~~The organization meets 0 factors~~

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

Data source

Documented process, Reports, Materials

Scope of review

NCQA reviews the organization's documented process.

NCQA also reviews the organization's complex case management system or reviews annotated screenshots of system functionality. The system must be in place throughout the look-back period.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

This element applies to all programs that were presented in Element B.

Factor 1: **Evidence-based clinical guidelines or algorithms**

The organization develops its complex case management system through one of the following sources:

- Clinical guidelines, ***or***
- Algorithms, ***or***
- Other evidence-based materials.

NCQA does not require the entire evidence-based guideline or algorithm to be imbedded in the automated system, but the components used to conduct assessment and management of patients must be imbedded in the system.

Factor 2: **Automatic documentation**

The complex case management system includes automated features that provide accurate documentation for each entry, (record actions or interaction with members, practitioners or providers) and use automatic date, time and user (user ID or name) stamps.

Factor 3: **Automated prompts**

The complex case management system includes prompts and reminders for:

- Next steps or follow-up care.
- Scheduled activities.
- Actions to be taken.
- Follow-up care related to the case management plan.

Exception

This element is NA if:

- The organization does not perform complex case management activities, *or*
- The organization is not delegated complex case management activities.

Related information

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 *QI 12: Delegation of QI.* NCQA evaluates the vendors documentation against the requirements. Refer to *Vendors* in *Appendix 3: Delegation and Automatic Credit Guidelines.*

Use of software for evidence-based clinical guidelines: The use of evidence-based clinical content licensed for use in the organization's case management system is not considered delegation, and delegation oversight is not required under *QI 12: Delegation of QI* if the organization maintains control over how the content is used and can customize it as needed. The evidence used to support the content must be cited.

Examples None.

Element G: Case Management Process

The organization's complex case management procedures address the following:

1. **Initial assessment of members' health status, including condition-specific issues.**
2. **Documentation of clinical history, including medications.**
3. **Initial assessment of the activities of daily living.**
4. **Initial assessment of behavioral health status, including cognitive functions.**
5. **Initial assessment of social determinants of health.**
6. **Initial assessment of life-planning activities.**
7. **Evaluation of cultural and linguistic needs, preferences or limitations.**
8. **Evaluation of visual and hearing needs, preferences or limitations.**
9. **Evaluation of caregiver resources and involvement.**
10. **Evaluation of available benefits.**
11. **Evaluation of available community resources.**
12. **Development of an individualized case management plan, including prioritized goals, that considers the member's and caregivers' goals, preferences and desired level of involvement in the case management plan.**
13. **Identification of barriers to meeting goals or complying with the plan.**
14. **Facilitation of member referrals to resources and a follow-up process to determine whether members act on referrals.**
15. **Development of a schedule for follow-up and communication with members.**
16. **Development and communication of member self-management plans.**
17. **A process to assess member's progress against case management plans developed for members.**

Summary of Changes

- This element was formerly QI 8, Element G.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 16-17 factors~~	~~The organization meets 14-15 factors~~	~~The organization meets 8-13 factors~~	~~The organization meets 3-7 factors~~	~~The organization meets 0-2 factors~~

Met	Partially Met	Not Met
The organization meets 14-17 factors	The organization meets 8-13 factors	The organization meets 0-7 factors

Data source Documented process

Scope of review NCQA reviews the organization's policies and procedures.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

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

Assessment and evaluation

Assessment and evaluation each require the case manager or other qualified individual to draw and document a conclusion about data or information collected. If the organization's case management system automatically generates suggestions, the case manager or other individual must still document their own conclusions. It is not sufficient to just have raw data or answers to questions. Policies describe the process to both collect information and document a summary of the meaning or implications of that data or information to the member's situation, so that it can be used in the case management plan.

The organization must draw a conclusion for each factor (unless otherwise stated in the explanation). This may be in separate summaries for each factor or in a combined summary, or in a combination of these.

Complex case management policies and procedures state why an assessment might not be appropriate for a factor (e.g., life-planning activities, in pediatric cases). The organization records the specific factor and the reason in the case management system and file.

***Factor 1:* Initial assessment of members' health status**

Complex case management policies and procedures specify the process for initial assessment of health status, specific to an identified condition and likely comorbidities (e.g., diabetes or heart failure for members with depression). The assessment should include:

- Screening for presence or absence of comorbidities and their current status.
- Member's self-reported health status.
- Information on the event or diagnosis that led to the member's identification for complex case management.
- Current medications, including schedules and dosages.

***Factor 2:* Documentation of clinical history**

Complex case management policies and procedures specify the process for documenting clinical history, including:

- Past hospitalization and major procedures, including surgery.
- Significant past illnesses and treatment history.
- Relevant past medications related to the member's condition.

Dates are a necessary component of accurate documentation of the member's clinical history. To the extent possible, the organization collects dates as part of documenting clinical history; however, NCQA does not penalize an organization if a member or other individual providing the information cannot provide dates. If dates are not present in the file, NCQA reviews the organization's complex case management policies and procedures. If the organization has a process for collecting dates as part of the clinical history, NCQA assumes the file does not include dates because the member or other individual giving information did not provide dates. The requirement is not met if the organization does not have a

process for collecting dates as part of the clinical history.

Factor 2 does not require assessment or evaluation.

Factor 3: **Initial assessment of activities of daily living**

Complex case management policies and procedures specify the process for assessing functional status relative to at least the six basic ADLs: bathing, dressing, going to the toilet, transferring, feeding and continence.

Factor 4: **Initial assessment of behavioral health status**

Complex case management policies and procedures specify the process for assessing behavioral health status, including:

- Cognitive functions:
  - The member's ability to communicate and understand instructions.
  - The member's ability to process information about an illness.
- Mental health conditions.
- Substance use disorders.

Factor 5: **Initial assessment of social determinants of health**

Complex case management policies and procedures specify the process for assessing social determinants of health,[1] which are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes, and risks that may affect a member's ability to meet case management goals.

Because social determinants of health are a combination of influences, the organization considers more than one social determinant of health, for a comprehensive overview of the member's health.

Factor 6: **Initial assessment of life planning activities**

Complex case management policies and procedures specify the process for assessing whether members have completed life planning activities such as wills, living wills or advance directives and health care powers of attorney and Medical or Physician Orders of Life-Sustaining Treatment (MOLST or POLST) forms.

If life planning activities are determined to be appropriate, the case manager documents what activities the member has taken and what documents are in place. If determined not to be appropriate, the case manager documents the reason in the case management record or file.

Providing life-planning information (e.g., brochure, pamphlet) to all members in complex case management meets the intent of this factor.

Factor 7: **Evaluation of cultural and linguistic needs**

Complex case management policies and procedures specify a process for assessing culture and language to identify potential barriers to effective communication or care and acceptability of specific treatments. Policies and procedures also include consideration of cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Factor 8: **Evaluation of visual and hearing needs**

Complex case management policies and procedures specify a process for assessing vision and hearing to identify potential barriers to effective communication or care.

[1] https://health.gov/healthypeople/priority-areas/social-determinants-health

Factor 9: **Evaluation of caregiver resources**

Complex case management policies and procedures specify a process for assessing the adequacy of caregiver resources (e.g., family involvement in and decision making about the care plan) during member evaluation.

Factor 10: **Evaluation of available benefits**

Complex case management policies and procedures specify a process for assessing the adequacy of health benefits regarding the ability to fulfill a treatment plan. The assessment includes a determination of whether the resources available to the member are adequate to fulfill the treatment plan.

Factor 11: **Evaluation of community resources**

Complex case management policies and procedures specify a process for assessing eligibility for community resources that supplement those for which the organization has been contracted to provide. At a minimum, these include:

- Community mental health.
- Transportation.
- Wellness programs.
- Palliative care programs.
- Nutritional support.

Factor 12: **Individual case management plan and goals**

Complex case management policies and procedures specify a process for creating a personalized case management plan that meets member needs and includes:

- Prioritized goals.
- Prioritized goals consider member and caregiver needs and preferences; they may be documented in any order, as long as the level of priority is clear.
- Time frame for reevaluation of goals.
- Time frames for reevaluation are specified in the complex case management plan.
- Resources to be utilized, including appropriate level of care.
- Planning for continuity of care, including transition of care and transfers.
- Collaborative approaches to be used, including level of family participation.

Factor 13: **Identification of barriers**

Complex case management policies and procedures address barriers to a member receiving or participating in a case management plan. A barrier analysis can assess:

- Language or literacy level.
- Access to reliable transportation.
- Understanding of a condition.
- Motivation.
- Financial or insurance issues.
- Cultural or spiritual beliefs.

- Visual or hearing impairment.
- Psychological impairment.

The organization documents that it assessed barriers, even if none were identified.

Factor 14: **Referrals to available resources**

Complex case management policies and procedures specify a process for facilitating referral to other health organizations, when appropriate.

Factor 15: **Follow-up schedule**

Complex case management policies and procedures specify a process for determining if follow-up is appropriate or necessary (e.g., after a member is referred to a disease management program or health resource). The case management plan contains a follow-up schedule that includes, but is not limited to:

- Counseling.
- Follow-up after referral to a disease management program.
- Follow-up after referral to a health resource.
- Member education.
- Self-management support.
- Determining when follow-up is not appropriate.

Factor 16: **Development and communication of self-management plans**

Complex case management policies and procedures specify a process for communicating the self-management plan to the member or caregiver (i.e., verbally, in writing). Self-management plans are activities that help members manage a condition and are based on instructions or materials provided to them or to their caregivers.

Factor 17: **Assessing progress**

Complex case management policies and procedures specify a process for assessing progress toward overcoming barriers to care and to meeting treatment goals, and for assessing and adjusting the care plan and its goals, as needed.

Exception

This element is NA if:

- The organization does not perform complex case management activities, ***or***
- The organization is not delegated complex case management activities.

Examples

Factor 3: **Activities of daily living**

- Dressing.
- Bathing.
- Toileting.
- Eating.
- Transferring (e.g., getting in and out of chairs).

Factor 4: **Cognitive functioning assessment**

- Alert/oriented, able to focus and shift attention, comprehends and recalls direction independently.
- Requires prompting (cueing, repetition, reminders) only under stressful situations or unfamiliar conditions.
- Requires assistance and some direction in specific situation (e.g., on all tasks involving shifting attention) or consistently requires low stimulus environment due to distractibility.
- Requires considerable assistance in routine situations.
- Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state or delirium.

Factor 5: **Social determinants of health**

- Current housing and housing security.
- Access to local food markets.
- Exposure to crime, violence and social disorder.
- Residential segregation and other forms of discrimination.
- Access to mass media and emerging technologies.
- Social support, norms and attitudes.
- Access, transportation and financial barriers to obtaining treatment.

Factor 7: **Cultural needs, preferences or limitations**

- Health care treatments or procedures that are discouraged or not allowed for religious or spiritual. reasons.
- Family traditions related to illness, death and dying.
- Health literacy assessment.
- Dietary restrictions.

Factor 9: **Caregiver assessment**

- Member is independent and does not need caregiver assistance.
- Caregiver currently provides assistance.
- Caregiver needs training, supportive services.
- Caregiver is not likely to provide assistance.
- Unclear if caregiver will provide assistance.
- Assistance needed but no caregiver available.

Factor 10: **Assessment of available benefits**

- Benefits covered by the organization and by providers.
- Services carved out by the purchaser.
- Services that supplement those the organization has been contracted to provide, such as:
  - Community mental health.
  - Medicaid.
  - Medicare.
  - Long-term care and support.
  - Disease management organizations.

- Palliative care programs.

Factor 14: **Assessment of barriers**

- Does the member understand the condition and treatment?
- Does the member want to participate in the complex case management plan?
- Does the member believe that participation will improve health?
- Are there financial or transportation limitations that may hinder the member from participating in care?
- Does the member have the mental and physical capacity to participate in care?

Source: Lorig, K. 2001. *Patient Education, A Practical Approach.* Sage Publications, Thousand Oaks, CA.186–192.

Factor 16: **Self-management**

Self-management includes ensuring that the member can:

- Perform activities of daily living (e.g., transfer/ambulation, bathing, dressing, toileting, eating/feeding).
- Perform instrumental activities of daily living (e.g., meals, housekeeping, laundry, telephone, shopping, finances).
- Self-administer medication (e.g., oral, inhaled or injectable).
- Self-administer medical procedures/treatments (e.g., change wound dressing).
- Manage equipment (e.g., oxygen, IV/infusion equipment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies).
- Maintain a prescribed diet.
- Chart daily weight, blood sugar.

Element H: Initial Assessment

An NCQA review of a sample of the organization's complex case management files demonstrates that the organization follows its documented processes for completing the following within 60 calendar days:

1. **Initial assessment of member health status, including condition-specific issues.**
2. **Documentation of clinical history, including medications.**
3. **Initial assessment of the activities of daily living.**
4. **Initial assessment of behavioral health status, including cognitive functions.**
5. **Initial assessment of social determinants of health.**
6. **Evaluation of cultural and linguistic needs, preferences or limitations.**
7. **Evaluation of visual and hearing needs, preferences or limitations.**
8. **Evaluation of caregiver resources and involvement.**
9. **Evaluation of available benefits.**
10. **Evaluation of available community resources.**
11. **Assessment of life-planning activities.**
12. **Beginning the assessment for at least one factor within 30 calendar days of identifying a**

member for complex case management.

Summary of Changes

- This element was formerly QI 8, Element H.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review for 10-12 factors and medium (60-89%) on no more than 2 factors~~	~~High (90-100%) on file review for 7-9 factors and medium (60-89%) on file review for no more than 2-5 factors~~	~~At least medium (60-89%) on file review for 12 factors~~	~~Low (0-59%) on file review for 1-6 factors~~	~~Low (0-59%) on file review for 7 or more factors~~

Met	Partially Met	Not Met
High (90-100%) on file review for at least 8 factors and medium (60-89%) on file review for any remaining factors	High (90%-100%) or medium (60-89%) on file review for 12 factors	Low (0-59%) on file review for any factor

Data source Records or files

Scope of review NCQA reviews initial assessments within a random sample of up to 40 complex case management files. Files are selected from active or closed cases that were identified during the look-back period and remained open for at least 60 calendar days during the look-back period, from the date when the member was identified for complex case management.

The organization must provide the identification date for each case in the file universe.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 12 months.

Explanation Initial assessment files are reviewed on the requirements outlined in Element G.

Documentation to meet the factors includes evidence that the assessment components were completed and documented results of each assessment. A checklist of assessment components without documentation of results does not meet the requirement.

Assessment components may be completed by other members of the care team and with the assistance of the member's family or caregiver. Assessment results for each factor must be clearly documented in case management notes, even if a factor does not apply.

If the member is unable to communicate because of infirmity, assessment may be completed by professionals on the care team, with assistance from the patient's family or caregiver.

If case management stops when a member is admitted to a facility and the stay is longer than 30 calendar days, a new assessment must be performed after discharge if the member is identified again for case management.

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.

Assessment and evaluation

Assessment and evaluation each require that the case manager or other qualified individual draw and document a conclusion about data or information collected. If the organization's case management system automatically generates suggestions, the case manager or other individual must still document their own conclusions. It is not sufficient to just have raw data or answers to questions. There is a documented summary of the meaning or implications of that data or information to the member's situation, so that it can be used in the case management plan.

The organization must draw a conclusion for each factor (unless otherwise stated in the explanation). This may be in separate summaries for each factor or in a combined summary, or in a combination of these.

Files excluded from review

The organization excludes files from review that meet the following criteria:

- Eligible members whom it cannot locate or contact after three or more attempts across a 2-week period, within the first 30 calendar days after identification, through at least two of the following mechanisms:
  - Telephone. Text messaging is an acceptable form of member contact and counts as one contact attempt by telephone.
  - Regular mail.
  - Email.
  - Fax.
- Members in complex case management for less than 60 calendar days during the look-back period.
  - The organization provides evidence of the member's identification date and that the member was in complex case management for less than 60 calendar days during the look-back period.
- Employees of the organization and their dependents.

Files that meet these criteria and are inadvertently included in the organization's file review are scored NA for all factors.

NCQA confirms that the files met the criteria for an NA score.

Factor 1: **Initial assessment of member's health status**

The file or case record documents a case manager's assessment of the member's current health status, including:

- Information on presence or absence of comorbidities and their current status.
- Self-reported health status.

- Information on the event or diagnosis that led to identification for complex case management.
- Current medications, including schedules and dosages.

Factor 2: **Documentation of clinical history**

The file or case record contains information on the member's clinical history, including:

- Past hospitalization and major procedures, including surgery.
- Significant past illnesses and treatment history.
- Relevant past medications related to the member's condition.

Dates are a necessary component of accurate documentation of the member's clinical history. To the extent possible, the organization collects dates as part of documenting clinical history; however, NCQA does not penalize an organization if a member or other individual providing the information cannot provide dates. If dates are not present in the file, NCQA reviews the organization's complex case management policies and procedures. If the organization has a process for collecting dates as part of the clinical history, NCQA assumes the file does not include dates because the member or other individual giving information did not provide dates. The requirement is not met if the organization does not have a process for collecting dates as part of the clinical history.

Factor 2 does not require assessment or evaluation.

Factor 3: **Initial assessment of activities of daily living**

The file or case record documents the results of the ADL assessment, including activities with which the member needs assistance. If the member does not need assistance, the file or case record notes reflect it.

Factor 4: **Initial assessment of behavioral health status**

The file or case record documents a case manager's assessment of:

- Cognitive functions:
  - The member's ability to communicate and understand instructions.
  - The member's ability to process information about an illness.
- Mental health conditions.
- Substance use disorders.

Factor 5: **Initial assessment of social determinants of health**

The file or case record documents the case manager's assessment of social determinants of health, which are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and assessment of risks that may affect the member's ability to meet goals.

Because social determinants of health are a combination of influences, the organization considers more than one social determinant of health, for a comprehensive overview of the member's health.

Factor 6: **Evaluation of cultural and linguistic needs**

The file or case record documents a case manager's evaluation of the member's culture and language needs and their impact on communication, care or acceptability of specific treatments. At a minimum, the case manager evaluates:

- Cultural health beliefs and practices.

- Preferred languages.

Factor 7: **Evaluation of visual and hearing needs**

The file or case record documents a case manager's evaluation of the member's vision and hearing. The document describes specific needs to consider in the case management plan and barriers to effective communication or care.

Factor 8: **Evaluation of caregiver resources**

The file or case record documents a case manager's evaluation of the adequacy of caregiver resources (e.g., family involvement in and decision making about the care plan) during member evaluation. Documentation describes the resources in place and whether they are sufficient for the member's needs, and notes specific gaps to address.

Factor 9: **Evaluation of available benefits**

The file or case record documents a case manager's evaluation of the adequacy of the member's health insurance benefits in relation to the needs of the treatment plan. The evaluation goes beyond checking insurance coverage; it includes a determination of whether available resources are adequate to fulfill the treatment plan.

Factor 10: **Evaluation of community resources**

The file or case record documents the case manager's evaluation of the member's eligibility for community resources and the availability of those resources and documents which the member may need.

For the community resources the member needs, the availability and member's eligibility is also recorded in the file. The case manager is not required to address community resources the member does not need.

If the member does not need community resources, the case file or notes reflect that no community resources are needed (e.g., "Member does not need any of the available community resources").

Factor 11: **Initial assessment of life planning activities**

The file or case record documents a case manager's assessment of whether the member has in place or has considered the need for wills, living wills or advance directives, Medical or Physician Orders of Life-Sustaining Treatment (MOLST or POLST) forms and health care powers of attorney. If life planning activities are determined to be appropriate, the case manager documents what activities the member has taken and what documents are in place. If determined not to be appropriate, the case manager documents the reason in the case management record or file.

Factor 12: **Beginning the assessment within 30 calendar days of identification**

The organization begins initial assessment within 30 calendar days of identifying a member for complex case management and completes the assessment within 60 calendar days of identifying the member. If the initial assessment begins after the first 30 calendar days of identifying the member, NCQA scores only factor 12 "No"; the remaining factors are not marked down.

NCQA scores any factor "No" if the initial assessment is completed more than 60 calendar days from identifying the member, unless the delay was due to circumstances beyond the organization's control:

- The member is hospitalized during the initial assessment period.
- The member cannot be contacted or reached through telephone, letter, email or fax.
- Natural disaster.
- The member is deceased.

The organization documents the reasons for the delay and actions it took to complete the assessment. The assessment may be derived from care or encounters occurring up to 30 calendar days before the member was identified if the information is related to the current episode of care (e.g., health history taken as part of disease management or during a hospitalization). Members are considered eligible once they are identified, unless they subsequently opt out or additional information reveals that they are ineligible.

Exception

This element is NA if:

The organization does not perform complex case management activities, *or*

The organization is not delegated complex case management activities.

Examples None.

Element I: Case Management-Ongoing Management

An NCQA review of a sample of the organization's complex case management files demonstrates that the organization follows its documented processes for:

1. **Development of case management plans, including prioritized goals, that take into account member and caregivers' goals, preferences and desired level of involvement in the complex case management program.**
2. **Identification of barriers to meeting goals and complying with the plans.**
3. **Development of schedules for follow-up and communication with members.**
4. **Development and communication of member self-management plans.**
5. **Assessment of progress against case management plans and goals, and modification as needed.**

Summary of Changes

- This element was formerly QI 8, Element I.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review for all 5 factors~~	~~High (90-100%) on file review for at least 3 factors and low (0-59%) for 0 factors~~	~~At least medium (60-89%) on file review for 5 factors~~	~~Low (0-59%) on file review for no more than 2 factors~~	~~Low (0-59%) on file review for 3 or more factors~~

Met	Partially Met	Not Met
High (90%-100%) on file review for at least 3 factors and medium (60-89%) on file review for any remaining factors	High (90%-100%) or medium (60-89%) on file review for 5 factors	Low (0-59%) on file review for any factors

Data source Records or files

Scope of review NCQA reviews assessments in a random sample of up to 40 case management files. Files are selected from active or closed cases that were identified during the look-back period and remained open for at least 60 calendar days during the look-back period, from the date when the member was identified for complex case management.

The organization must provide the identification date for each case in the file universe.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 12 months.

Explanation Each case file contains evidence that the organization completed the five factors listed according to its complex case management procedures in Element G.

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.

Files excluded from review

The organization excludes files from review that meet these criteria:

- Eligible members whom it cannot locate or contact after three or more attempts across a 2-week period, within the first 30 calendar days after eligibility, through at least two of the following mechanisms:
  - Telephone. Text messaging is an acceptable form of member contact and counts as one contact attempt by telephone.
  - Regular mail.
  - Email.
  - Fax.
- Eligible members enrolled in complex case management for less than 60 calendar days during the look-back period.
  - The organization provides evidence of the member's identification date and that the member was in complex case management for less than 60 calendar days during the look-back period.
- Employees of the organization and their dependents.

Files that meet these criteria and are inadvertently included in the organization's file review are scored NA for all factors.

NCQA confirms that the files met the criteria for an NA score.

Factor 1: **Case management plans and goals**

The file or case record documents a plan for case management that is specific to the member's situation and needs, and includes goals that reflect issues identified in the member assessment and the supporting rationale for goal selection. Goals are specific, measurable and timebound. To be timebound, each goal must have a target completion date.
Case management goals are prioritized. The organization prioritizes goals using high/low, numeric rank or other similar designation. Priorities reflect input from the member or a caregiver, demonstrating the member or caregiver's preferences and priorities. Designating goals as long-term or short-term is not sufficient to meet the requirement. The organization must rank or prioritize goals.

Factor 2: **Identification of barriers**

Barriers are related to the member or to the member's circumstances, not to the complex case management process. The organization documents barriers to the member meeting the goals specified in the complex case management plan.

Factor 3: **Follow-up and communication with members**

The file or case record documents the next scheduled contact with the member, including the scheduled time or time frame and method, which may be an exact date or relative (e.g., "in 2 weeks").

Factor 4: **Self-management plan**

The file or case record documents a self-management plan that includes actions the member agrees to take to manage a condition or circumstances. The organization documents that the plan has been communicated to the member. Communication may be verbal or written. Documentation includes the member's acknowledgment of and agreement to expected actions.

Factor 5: **Assessment of progress**

The file or case record documents the member's progress toward goals. If the member does not demonstrate progress over time, the organization reassesses the applicability of the goals to the member's circumstances and modifies the goals, as appropriate.

Exception

This element is NA if:

- The organization does not perform complex case management activities, ***or***
- The organization is not delegated complex case management activities.

Examples

Factors 1–5: **Case Management—Ongoing Management**

Member diagnosis: Severe mental illness (depression); chronic homelessness (unstable housing for 8 months)	
Identification date: 1/5/[year]	Initial assessment completed: 1/30/[year]
Goal 1:	Secure stable housing for member by 2/11/[year]. (Factor 1**)**
Goal case notes: Member did not identify a family or friend caregiver. Member expresses a desire for a home and is willing to accept case manager's help to manage other conditions, once in stable housing. (Factor 1)	

Strategies to achieve goal: Referral to community housing resources; secure temporary safe housing, pending a more permanent solution; accompany member to housing services. *Barriers to goal:* Member was previously evicted from temporary shelter due to unwillingness to comply with shelter staff rules. (Factor 2) *Progress assessment:* Member moved out of initial temporary shelter because he felt his belongings were unsafe. Asked for help getting into a home where he can lock up his belongings. CM adjusted completion date to 2/21/[year] and investigated group housing. (Factor 5)	
Goal 1 completed:	2/16/[year]. ***Note:*** *Member was accepted into adult male group housing, once he understood and accepted house rules, is comfortable with secure locker for belongings.* (Factor 5)

Goal 2:	Improve member's Patient Health Questionnaire-9 (PHQ-9) score from baseline (23 at initial assessment 1/30/[year]) over 3–6 months. Improve 5 points from baseline by 4/30/[year]. Improve 11 points from baseline by 7/30/[year]. (Factor 1)
Goal case notes: Member did not identify a family or friend caregiver. Member expresses a desire for a home and is willing to accept case manager's help to manage other conditions, once in stable housing. Member feels that stable housing will help depression and is willing to attend therapy sessions. (Factor 1) *Strategies to achieve goal:* Implement a reminder system for taking medications; arrange transportation for therapist visits; check in weekly to discuss progress. *Barriers to goal:* Member uncertain about how to get to therapy sessions and states that he feels overwhelmed by having to change buses and remember schedules. Member said his medication has been stolen in shelters before. (Factor 2) *Progress assessment:* Member feels his medications are safe in group home lockers. CM helped the member set up a calendar pill case and clock alarm as medication reminders. CM arranged van transportation to twice weekly therapy sessions. CM assessed PHQ score at weekly call on 4/28/[year]. Score was 16 (9 less than baseline). Member stated that housing greatly improved depression. Therapy sessions adjusted to weekly. CM assessed PHQ score at weekly call on 7/28/[year]. Score was 12 (11 less than baseline). (Factor 5)	
Goal 2 completed:	7/28/[year]. ***Note:*** *Member attends therapy. Member can navigate bus lines without anxiety; assisted transportation to sessions discontinued.* (Factor 5)
Follow-up and	CM scheduled weekly follow-up calls at 5pm on Fridays

communication plan:	via the group home's phone line. CM gave member direct emergency line and is working to secure cell phone for member. (Factor 3)

Self-management plan:	1. Member will attend weekly follow-up calls on Fridays at 5pm via ***-***-****. 2. Member will continue to follow rules of group home. 3. Member will alert CM if changes to housing occur. 4. Member will use alarm clock reminders to take medication on schedule. Member and CM will discuss monthly refills to medications box. 5. CM arranges medication to be mailed to group home; member agrees to verify medication with CM during weekly calls. 6. Member attends therapy sessions and alerts group home staff to dramatic changes in mood (e.g., suicidal ideation). 7. Member will work with group home staff and other residents to learn bus routes and how to change buses on route. (Factor 4)

Element J: Measuring Effectiveness

The organization annually measures the effectiveness of its complex case management program using three measures. For each measure, the organization:

1. **Identifies a relevant process or outcome.**
2. **Uses valid methods that provide quantitative results.**
3. **Sets a performance goal.**
4. **Clearly identifies measure specifications.**
5. **Collects data and analyzes results.**
6. **Identifies opportunities for improvement, if applicable.**

Summary of Changes

- This element was formerly QI 8, Element J.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 4-6 factors~~	~~The organization meets 3 factors~~	~~The organization meets 2 factors~~	~~The organization meets 1 factor~~	~~The organization meets 0 factors~~

Met	Partially Met	Not Met
The organization meets	The organization meets	The organization meets

3-6 factors	2 factors	0-1 factors

Data source Reports

Scope of review *For Initial Surveys:* NCQA reviews the organization's most recent annual data evaluation report.

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

NCQA scores this element for each measure. The element score is the average of the scores for all measures.

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

For Renewal Surveys: 24 months.

Explanation This element applies to all programs that were presented in Element C.

Factor 1: **Relevant process or outcome**

The organization selects a combination of process or outcome measures that have significant bearing on the complex case management program's population or on a defined subset of the population.

Note:

- *Participation rates do not qualify for this element.*
- *If the organization uses SF-8®, SF-12® or SF-36® to measure health status, results may count for two measures of effectiveness: one each for physical and mental health functioning.*
- *The organization may use a member experience activity conducted as one measure.*

Factor 2: **Valid methods and quantitative results**

NCQA considers the following criteria when evaluating a measure's validity:

Numerator and denominator.

Sampling methodology.

Sample size calculation.

Measurement periods and seasonality effects.

Factor 3: **Performance goal**

The organization establishes an explicit, quantifiable performance goal for each measure. The goal may be based on external benchmarks.

Factor 4: **Measure specifications**

The organization describes the data source, the eligible population, coding or other means of identifying the clinical process or outcome and any adaptation of HEDIS Effectiveness of Care measures used. The intent is to provide measure specifications that have enough detail to guide valid measurement.

Factor 5: **Quantitative and qualitative analysis**

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

For remeasurement, the organization conducts quantitative analysis, and conducts qualitative analysis of each measure if quantitative analysis demonstrates that

stated goals were not met.

Refer to *Appendix 5: Glossary* for the full definition of and requirements for quantitative analysis and qualitative analysis.

Factor 6: **Opportunities for improvement**

The organization uses the results of its analysis to prioritize opportunities for improvement, which may be different each time the organization measures and analyzes the data. The organization is not required to identify a specific number of improvement opportunities.

Exception

This element is NA if:

- The organization does not perform complex case management activities, ***or***
- The organization is not delegated complex case management activities.

Factor 6 is NA if no opportunities for improvement are identified by the organization, based on results. The organization provides documentation to support its conclusion.

Related information

NCQA reviews the measures from this element in the QI 8 Measures Workbook (available in the IRT under the "File Submission Instructions" tab) or reports.

Examples

Outcome measures

- Measures of effectiveness for chronic conditions based on HEDIS, with specifications adapted to draw a denominator from the case management population only.
- Measures for care of chronic conditions based on Partnership for Quality Measurement (PQM) measures, with specifications adapted to draw a denominator from the complex case management population at the plan level.
- Health status (e.g., SF-36®, SF-12® or SF-8® results).
- Experience with complex case management services.
- Use of service measures for specific populations for which there is consensus that an increase or decrease represents improvement (e.g., inpatient days/1,000; ED visits, admissions/1,000; medication compliance; total cost per member per month [PMPM]).
- Measures of ambulatory-care-sensitive admission, which are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or severe disease.

Process measures

- The period from when an individual eligible for the complex case management program is identified to when the individual receives complex case management services.
- The number of visits required to assess an individual for inclusion in the complex case management program.
- Consistency among complex case management care team in carrying out planned actions.

PHM 7: 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 A: Measuring Effectiveness

At least annually, the organization conducts a comprehensive analysis of the impact of its PHM strategy that includes the following:

1. **Quantitative results for relevant clinical, cost/utilization and experience measures.**
2. **Comparison of results with a benchmark or goal.**
3. **Interpretation of results.**

Summary of Changes

- This is a new standard and element to the MBHO product.

Scoring

Met	Partially Met	Not Met
The organization meets 3 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.

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

Documentation

For First Surveys: NCQA reviews the organization's plan for annual comprehensive analysis of its PHM strategy impact or the organization's most recent annual comprehensive analysis of PHM strategy impact.

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

Look-back period

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

For Renewal Surveys: 24 months.

Explanation

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

The organization conducts an annual comprehensive evaluation of the impact of its PHM strategy.

Factor 1: **Measurement**

The organization's evaluation of the impact of its strategy includes at least four measures, that includes:

- *One* clinical measure, ***and***
- *One* cost or utilization measure ***and***
- *One* member feedback measure from *two different programs*.

Relevant measures align with the goals for the areas of focus, activities or programs described in *PHM 1: PHM Strategy*, Element A. The organization describes why measures are relevant. Measures may focus on one segment of the population or on populations across the organization.

Clinical measures. Measures can be activities, events, occurrences or outcomes for which data can be collected for comparison with a threshold, benchmark or prior performance. Clinical measures may be:

1. *Outcome measures:* Incidence or prevalence rates for desirable or undesirable heath status outcomes (e.g., infant mortality), ***or***
2. *Process measures:* Measures of clinical performance based on objective clinical criteria defined from practice guidelines or other clinical specifications (e.g., immunization rates).

Cost/utilization measures. Utilization is an unweighted count of services (e.g., inpatient discharges, inpatient days, office visits, prescriptions). Utilization measures capture the frequency of services provided by the organization. Cost-related measures can be used to demonstrate utilization. The organization measures cost, resource use or utilization.

Cost of care considers the mix and frequency of services, and is determined using actual unit price per service or unit prices on a standardized fee schedule. Examples of cost of care measurement include:

- Dollars per episode, overall or by type of service.
- Dollars per member, per month (PMPM), overall or by type of service.
- Dollars per procedure.

Resource use considers the cost of services in addition to the count of services across the spectrum of care, such as the difference between a major surgery and a 15-minute office visit.

Experience

The organization obtains member feedback from at least two programs (e.g., disease management or wellness programs), using focus groups or satisfaction surveys. Feedback is specific to the programs being evaluated and includes at least one of the following measures:

- Information about the overall program.
- The program staff.
- Usefulness of the information disseminated.
- Members' ability to adhere to recommendations.
- Percentage of members indicating that the program helped them achieve health goals.

The organization may supplement member survey or focus group data with member complaint data.

CAHPS and other general survey questions do not meet the intent of this element.

***Factor 2:* Quantitative analysis**

The organization performs a quantitative analysis of the four measure results from factor 1. The organization draws conclusions about what the results mean, but trending is not required for this analysis.

***Factor 3:* Qualitative analysis**

For initial measurement, the organization conducts qualitative analysis of each measure result from factor 1.

For remeasurement, the organization conducts qualitative analysis of each measure result from factor 1 if quantitative analysis demonstrates that stated goals were not met.

The organization assesses measure results together for a comprehensive qualitative analysis of the effectiveness of its PHM strategy. The analysis includes an interpretation of results, to give the organization insight into its PHM programs and strategy, and helps it understand the programs' effectiveness and impact on areas of focus.

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

Note:

- *Participation rates do not qualify for this element.*
- *If the organization uses SF-8®, SF-12® or SF-36® to measure health status, results may count for two measures of effectiveness: one each for physical and mental health functioning.*

Exceptions

None.

Examples

Factor 1: Utilization and experience measures

- Measures of **utilization** include measures of waste, overutilization, access, cost or underutilization.
- Measures of **experience** include the Patient Health Questionnaire (PHQ-9), Patient-Reported Outcomes Measurement Information System (PROMIS) tools and program-specific surveys.

Element B: Improvement and Action

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

1. Identify opportunities for improvement.

2. Act on one opportunity for improvement.

Summary of Changes

- This is a new standard and element to the MBHO product.

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 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 on opportunity for improvement**

The organization acts on at least one identified opportunity for improvement.

Exceptions

None.

Examples None.

PHM 8: Delegation of PHM

If the organization delegates NCQA-required PHM 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 PHM activities.

Element A: Delegation Agreement

The written delegation agreement:

1. **Is mutually agreed upon.**
2. **Describes the delegated activities and the responsibilities of the organization and the delegated entity.**
3. **Requires at least semiannual reporting by the delegated entity to the organization.**
4. **Describes the process by which the organization evaluates the delegated entity's performance.**
5. **Describes the process for providing member experience and clinical performance data to its delegates when requested.**
6. **Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.**

Summary of Changes

- This is a new standard and element to the MBHO product.

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 Materials

Scope of review

Product lines

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

Documentation

NCQA reviews delegation agreements in effect during the look-back period of up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

Delegation agreements implemented on or after January 1, 2019, must include a description of the process required in factor 5.

For delegation agreements in place prior to January 1, 2019, the organization may provide documentation that it notified the delegate of the process required in factor 5. This documentation of notification is not required to be mutually agreed upon.

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim Surveys and First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

This element may not be delegated.

This element applies to agreements that are in effect during the look-back period.

The delegation agreement describes all delegated PHM activities. A generic policy statement about the content of delegated arrangements does not meet this element.

***Factor 1:* Mutual agreement**

Delegation activities are mutually agreed on before delegation begins, in a dated, binding document or communication between the organization and the delegated entity.

NCQA considers the effective date specified in the delegation agreement as the mutually agreed-upon effective date. The effective date may be before or after the signature date on the agreement. If the agreement has no effective date, NCQA considers the signature date (the date of last signature) as the mutually agreed upon effective date.

NCQA may accept other evidence of the mutually agreed-upon effective date: a letter, meeting minutes or other form of communication between the organization and the delegate that references the parties' agreement on the effective date of delegated activities.

NCQA requires submitted evidence for all other delegation factors to consider the same mutually agreed-upon date as the effective date for the delegate's performance of delegated activities.

***Factor 2:* Assigning responsibilities**

The delegation agreement or an addendum thereto or other binding communication between the organization and the delegate specifies the PHM activities:

- Performed by the delegate, in detailed language.
- Not delegated, but retained by the organization.
- The organization may include a general statement in the agreement addressing retained functions (e.g., the organization retains all other PHM functions not specified in this agreement as the delegate's responsibility).

If the delegate subdelegates an activity, the delegation agreement must specify that the delegate or the organization is responsible for subdelegate oversight.

***Factor 3:* Reporting**

The organization determines the method of reporting and the content of the reports, but the agreement must specify:

- That reporting is at least semiannual.
- The information reported by the delegate about delegated activities.
- How, and to whom, information is reported (i.e., joint meetings or to appropriate committees or individuals in the organization).

The organization must receive regular reports from all delegates, including NCQA-Accredited/Certified delegates.

***Factor 4:* Performance monitoring**

The delegation agreement specifies how the organization evaluates the delegate's performance.

***Factor 5:* Providing member and clinical data**

The organization's delegation agreement describes what the delegate must do to obtain the following data when needed, or on an ongoing basis:

- **Member experience data:** Complaints, CAHPS survey results or other data collected on members' experience with the delegate's services.
- **Clinical performance data:** HEDIS measures, claims and other clinical data collected by the organization. The organization may provide data feeds for relevant claims data or clinical performance measure results.

Factor 6: Consequences for failure to perform

The delegation agreement specifies consequences if a delegate fails to meet the terms of the agreement and, at a minimum, circumstances that would cause revocation of the agreement.

Exception

This element is NA if the organization does not delegate PHM activities.

Examples None.

Element B: Predelegation Evaluation

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Summary of Changes

- This is a new standard and element to the MBHO product.

Scoring

Met	Partially Met	Not Met
The organization evaluated delegate capacity before delegation began	The organization evaluated delegate capacity after delegation began	The organization did not evaluate delegate capacity

Data source Reports

Scope of review

Product lines

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

This element applies if delegation was implemented in the look-back period.

Documentation

NCQA reviews the organization's predelegation evaluation of up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim Surveys and First Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

This element may not be delegated.

NCQA-Accredited/Certified delegates

Automatic credit is available for this element if all delegates are NCQA-Accredited health plans, MBHOs or CMOs, NCQA-Accredited/Certified DMOs, NCQA-Accredited PHP Organizations or NCQA-Prevalidated Health IT Solutions, unless the element is NA.

Note: *For organizations that have both NCQA-Accredited/Certified and non-Accredited/Certified delegates:*

- *NCQA-Accredited/Certified delegates are eligible for automatic credit.*
- *Non-Accredited/Certified delegates are reviewed and scored accordingly.*

Predelegation evaluation

The organization evaluated the delegate's capacity to meet NCQA requirements within 12 months prior to implementing delegation. The evaluation may include a review of the delegate's structure, processes, and staffing in order to determine its capability to perform the delegated function.

NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date.

If the time between the predelegation evaluation and implementation of delegation exceeds the 12 months, the organization conducts another predelegation evaluation.

If the organization amends the delegation agreement to include additional PHM activities within the look-back period, it performs a predelegation evaluation for the additional activities.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements have been in effect for longer than the look-back period.

Related information

Use of collaboratives. The organization may enter into a statewide collaboration to perform any or all of the following:

- Predelegation evaluation.
- Annual evaluation.
- Annual audit of files.

The collaborative must agree on the use of a consistent audit tool and must share data. Each organization is responsible for meeting NCQA delegation standards, but may use the shared data collection process to reduce burden.

Examples

Predelegation evaluation

- Site visit.
- Telephone consultation.

- Documentation review.
- Committee meetings.
- Virtual review.

Element C: Review of PHM Program

For arrangements in effect for 12 months or longer, the organization:

1. **Annually reviews its delegate's PHM program.**
2. **Annually audits complex case management files against NCQA standards for each year that delegation has been in effect, if applicable.**
3. **Annually evaluates delegate performance against NCQA standards for delegated activities.**
4. **Semiannually evaluates regular reports, as specified in Element A.**

Summary of Changes

- This is a new standard and element to the MBHO product.

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

Factor 1 applies to Interim Surveys for all product lines.

All factors in this element apply to First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews evidence of the organization's review from up to four randomly selected delegates, or all delegates if the organization has fewer than four.

For All Surveys: NCQA reviews the organization's review of the delegate's PHM program (factor 1).

For First Surveys: NCQA reviews the organization's most recent annual review, audit, performance evaluation and semiannual evaluation.

For Renewal Surveys: NCQA reviews the organization's most recent and the previous year's annual reviews, audits, performance evaluations and four semiannual evaluations.

The score for the element is the average of the scores for all delegates.

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.

NCQA-Accredited/Certified delegates

Automatic credit is available for factors 2 and 3 if all delegates are NCQA-Accredited health plans, MBHOs or CMOs, or NCQA-Accredited/Certified DMOs, unless the element is NA.

Automatic credit is available for factor 3 if all delegates are NCQA-Prevalidated Health IT Solutions or NCQA-Accredited PHP Organizations, unless the element is NA.

Note: *For organizations that have both NCQA-Accredited/Certified and non-Accredited/Certified delegates:*

- *NCQA-Accredited/Certified delegates are eligible for automatic credit.*
- *Non-Accredited/Certified delegates are reviewed and scored accordingly.*

Factor 1: **Review of the PHM program**

Appropriate organization staff or committee reviews the delegate's PHM program. At a minimum, the organization reviews parts of the PHM program that apply to the delegated functions.

Factor 2: **Annual file audit**

If the organization delegates complex case management, it audits the delegate's complex case management files against NCQA standards. The organization uses either of the following to audit the files:

- 5% or 50 of its files, whichever is less.
- The NCQA "8/30 methodology" available at http://www.ncqa.org/Programs/Accreditation/PolicyUpdatesSupportingDocuments.aspx

The organization bases its annual audit on the responsibilities described in the delegation agreement and the appropriate NCQA standards.

Factor 3: **Annual evaluation**

No additional explanation required.

Factor 4: **Evaluation of reports**

No additional explanation required.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements have been in effect for less than 12 months.

Factor 2 is NA if the organization does not delegate complex case management activities.

Factors 2–4 are NA for Interim Surveys.

Related information

Use of collaboratives. The organization may enter into a statewide collaboration to perform any or all of the following:

- Predelegation evaluation.
- Annual evaluation.
- Annual audit of files.

The collaborative must agree on the use of a consistent audit tool and must share data. Each organization is responsible for meeting NCQA delegation standards, but may use the shared data collection process to reduce burden.

Examples None.

Element D: Opportunities for Improvement

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.

Summary of Changes

- This is a new standard and element to the MBHO product.

Scoring

Met	Partially Met	Not Met
The organization has acted on identified problems, if any, at least once in each of the past 2 years that the delegation arrangement has been in effect	The organization took inappropriate or weak action, or acted only in the past year	The organization has not acted on identified problems

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

NCQA reviews reports for opportunities for improvement if applicable of up to four randomly selected delegates, or from all delegates, if the organization has fewer than four, and for evidence that the organization took appropriate action to resolve issues.

For First Surveys: NCQA reviews the organization's most recent annual review and follow-up on improvement opportunities.

For Renewal Surveys: NCQA reviews the organization's most recent and previous year's annual reviews and follow-up on improvement opportunities.

The score for the element is the average of the scores for all delegates.

Look-back period

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

For Renewal Surveys: 24 months.

Explanation This element may not be delegated.

NCQA-Accredited/Certified delegates

Automatic credit is available for this element if all delegates are NCQA-Accredited health plans, MBHOs or CMOs, NCQA-Accredited/Certified DMOs, NCQA-Accredited PHP Organizations or NCQA-Prevalidated Health IT Solutions, unless the element is NA.

Note: *For organizations that have both NCQA-Accredited/Certified and non-Accredited/Certified delegates:*

- *NCQA-Accredited/Certified delegates are eligible for automatic credit.*
- *Non-Accredited/Certified delegates are reviewed and scored accordingly.*

Identify and follow up on opportunities

The organization uses information from its predelegation evaluation, ongoing reports, or annual evaluation to identify areas of improvement.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements have been in effect for less than 12 months.
- The organization has no opportunities to improve performance.
  - NCQA evaluates whether this conclusion is reasonable, given assessment results.

Examples None.

Network Management

NET 1: Availability of Practitioners and Providers (former QI 3)

The organization maintains sufficient numbers and types of behavioral health practitioners in its network.

Intent

The organization maintains an adequate network of behavioral healthcare practitioners and providers, and monitors how effectively this network meets the needs and preferences of its members.

Element A: Cultural Needs and Preferences

The organization annually:

1. **Assesses the cultural, ethnic, racial and linguistic needs and preferences of its members.**
2. **Adjusts the availability of practitioners within its network, if necessary.**

Summary of Changes

- This element was formerly QI 3, Element A.
- Added veteran/military status, age, urban/rural geography, disability to factor 1.
- Revised the explanation to clarify that factor 1 does not compare practitioner and member demographics.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 2 factors~~	~~No scoring option~~	~~The organization meets 1 factor~~	~~No scoring option~~	~~The organization meets 0 factors~~

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

For Initial 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 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.

***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 disabilities.

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 intent of this assessment is not 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 the 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 the 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 B: ~~Ensuring~~ Availability and Accessibility

To evaluate the availability of behavioral healthcare practitioners and providers within its delivery system, the organization:

1. **Defines the types of behavioral healthcare practitioners and providers.**
2. **Establishes quantifiable and measurable standards for the number of each type of behavioral healthcare practitioner and provider.**
3. **Establishes quantifiable and measurable standards for the geographic distribution of each type of behavioral healthcare practitioner and provider.**
4. **Annually analyzes performance against the standards.**
5. ~~**Annually identifies opportunities for improvement.**~~
6. ~~**Annually implements interventions.**~~
7. ~~**Annually measures the effectiveness of interventions.**~~

Summary of Changes

- This element was formerly QI 3, Element B.
- The element title was renamed from "Ensuring Availability" to "Availability and Accessibility."
- Expanded the definition of "practitioner/provider" in the factor 1 explanation.
- Added requirements to meet factors 2 and 3.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization~~	~~The organization~~	~~The organization~~	~~The organization~~	~~The organization~~

~~meets 7 factors~~	~~meets 6 factors~~	~~meets 4-5 factors~~	~~meets 2-3 factors~~	~~meets 0-1 factors~~

Met	Partially Met	Not Met
The organization meets 6-7 factors	The organization meets 4-5 factors	The organization meets 0-3 factors

Summary of Changes

Data source Documented process, Reports

Scope of review NCQA reviews policies and procedures for factors 1–3.

For Initial Surveys: NCQA also reviews the organization's most recent annual analysis, opportunities, interventions and measurement of its interventions report.

For Renewal Surveys: NCQA also reviews the most recent and previous year's annual analysis, opportunities, interventions and measurement of its intervention reports.

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.

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

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

Factor 1: **Types of practitioners and providers**

The organization defines all types of behavioral healthcare practitioners and providers within its delivery system across the continuum of care, not just high-volume practitioners. ~~At a minimum, it includes MD, doctoral-level, non-MD and non-doctoral level, non-MD practitioners; and inpatient, residential and ambulatory provider organizations~~ **"**It includes**:**

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

The organization's performance score will be lower if it does not evaluate all factors for both practitioners and providers.

Factor 2: **Standards for the number of behavioral healthcare practitioners and providers**

The organization expresses the standard for number of practitioners and providers in ~~one of two of~~ the following ways:

- The ratio of each type of behavioral health practitioner and provider to the number of members
- The percentage of practitioners who have submitted in-network claims for a specified numbers of unique members.
- The ratio of behavioral health care practitioners and providers of each type accepting new patients to the number of members.

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

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

- Acceptable distance to a practitioner or provider site from the member's home.
- Acceptable driving time to a behavioral healthcare practitioner or provider site from the member's home.
- Proximity of practitioner or provider site to public transportation.

Availability of 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 the stated goals were not met.

To analyze its performance against 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 the glossary appendix for the full definition of and requirements for quantitative analysis and qualitative analysis.

Factor 5: **Identifying opportunities for improvement**

The organization identifies and prioritizes as many opportunities for improvement as possible, based on assessment results. The organization also identifies issues on the basis of their significance to members. Analysis of assessment results indicates how the organization decided to pursue opportunities for improvement.

Factor 6: **Implementing interventions**

The organization identifies interventions it can take to reduce identified barriers to improvement or to causes of not meeting the standards.

Factor 7: **Measuring effectiveness**

The organization uses its methodology to evaluate interventions, to assess whether they had the desired effect. Evaluation is in measurable terms and may include remeasurement against the original standard or targeted, intermediate measurement of specific interventions. 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

Factors 5–7 are NA if the organization's assessment does not identify opportunities for improvement. NCQA evaluates whether this conclusion is reasonable, given assessment results.

Factor 7 is NA for Initial Surveys.

Examples

Common types of behavioral healthcare practitioners

- Psychiatrists.
- Addiction medicine specialists.
- Clinical psychologists.
- Clinical social workers.
- Psychiatric clinical nurse specialists.
- Substance abuse counselors.
- Marriage and family therapists.
- Psychiatric Nurse Practitioners

NUMBER OF PRACTITIONERS		
Practitioner Type	**Measure**	**Performance Goal**
Psychiatrist	Ratio of practitioner to members	1:2,000
Clinical psychologist	Ratio of practitioner to members	1:15,000
Licensed clinical social worker	Ratio of practitioner to members	1:10,000
Marriage and family counselor	Ratio of practitioner to members	1:3,000

GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS, MILES		
Practitioner Type	**Measure**	**Performance Goal**
Psychiatrist	Members within 10 miles	95%
Clinical psychologist	Members within 20 miles	95%
Licensed clinical social worker	Members within 20 miles	95%
Marriage and family counselor	Members within 10 miles	95%

GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS, DRIVING TIME		
Practitioner Type	**Measure**	**Performance Goal**
Psychiatrist	Members within 15 minutes driving time	95%
Clinical psychologist	Members within 25 minutes driving time	95%
Licensed clinical social worker	Members within 25 minutes driving time	95%
Marriage and family counselor	Members within 15 minutes driving time	95%

NET 2 ~~QI 4~~: Accessibility of Services (Former QI 4)

The organization establishes mechanisms to ensure access to behavioral healthcare and member services.

Intent

The organization provides and maintains appropriate access to behavioral healthcare and member services.

Element A: Assessment Against Access Standards

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

1. ~~**Collecting data about members' ability to access**~~ **care for an emergency crisis.**
2. **Non-life-threatening emergency within 6 hours.**
3. **Urgent care within 48 hours*.**
4. **Initial visit for routine care within 10 business days.**~~**and follow-up routine care**~~
5. **Follow-up routine care.**

6~~2~~. Analyzing the data.

~~**3. Identifying opportunities for improvement.**~~

~~**4. Implementing interventions.**~~

~~**5. Measuring the effectiveness of interventions.**~~

Summary of Changes

- The element was formerly QI 4, Element A.
- Revised the factors to evaluate each type of care separately.
- Added a factor for care for a crisis.
- Updated the scope of review and explanation to clarify use of behavioral health crisis units.

- Updated the explanation to include new requirement to meet factor 6.
- Removed factors 3–5, which are addressed *NET 3: Assessment of Network Adequacy.*
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 5 factors~~	~~The organization meets 4 factors~~	~~The organization meets 3 factors~~	~~The organization meets 2 factors~~	~~The organization meets 0-1 factors~~

Met	Partially Met	Not Met
The organization meets 4-6 factors	The organization meets 3 factors	The organization meets 0-2 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. 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, psychiatric ED, mobile crisis response teams or the ED, NCQA reviews the organization's report, policies or other documentation.

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.

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

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 assists 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 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).

Directing members to the ED. The organization meets the "non-life-threatening emergencies" component of factor 1 if it directs members with non-life-threatening emergencies to the ED or behavioral health crisis units. The organization incorporates 988 Suicide and Crisis Lifeline into it's response for 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.

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

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.

***Factor 6:* Analysis**

Data collection, quantitative and qualitative analyses. To analyze its performance against the access standard from factors 1–5, the organization collects data using measures that allow direct comparison against standards it defines. This includes the percentage of appointments scheduled within the time frames in factors 1–5.

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 *Appendix 5: Glossary* for the full definition of and requirements for quantitative analysis and qualitative analysis.

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 crisis intervention resources or ED instead of being scheduled for a doctor visit.
- Customer Services telephone script that instructs staff to direct members with non-life-threatening emergencies to crisis intervention resources ~~ED~~ or behavioral health crisis unit.

Element B: Assessment Against Accommodation Standards

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

1. **Collecting data about practitioner's availability/ability to schedule appointments during standard working hours, evenings, weekends.**
2. **Analyzing the data.**

Summary of Changes

- This is a new element.

Scoring

Met	Partially Met	Not Met
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.

Look-back period For each factor, the organization separates prescribers and non-prescribers.
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 assists 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 *Appendix 5: Glossary* for the full definition of and requirements for quantitative analysis and qualitative analysis.

Examples

Data collection and analysis

- Analysis of member complaints by accommodation standards.
- Member surveys that ask questions directly related to the 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

The organization monitors access to health care services and takes action to improve it.

Intent

The organization provides members adequate network access for needed behavioral health care services.

Element A: Assessment of Member Experience Accessing the Network

The organization annually identifies gaps in networks specific to geographic areas or types of practitioners or providers by:

1. **Using analysis results related to member experience with network adequacy for behavioral healthcare services from ME 3.**
2. **Compiling and analyzing behavioral healthcare requests for and utilization of out-of-network services.**

Summary of Changes

- This is a new standard and element to the MBHO product.

Scoring

Met	Partially Met	Not Met
The organization meets 2 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 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 the previous year's reports.

Look-back period

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

For Renewal Surveys: 24 months.

Explanation

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.

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

***Factors 1:* Analysis of data from member experience, complaints and appeals**

The organization completes a quantitative and qualitative analysis, by product/product line, of member complaint and appeal data related to network adequacy (e.g., requests for out-of-network services, appeals, complaints specific to access) and member experience (CAHPS or member experience survey).

Analysis of complaints, appeals and experience related to network adequacy may be included in the overall analysis of member experience Documentation must clearly reflect results/analysis/opportunities by product line.

***Factor 4:* Requests for and utilization of out-of-network services**

The organization compiles data on member requests for out-of-network services and on actual out-of-network utilization to identify and monitor issues with access to behavioral healthcare services practitioners and providers. The organization reports data per thousand members at the product-line level.

The organization conducts quantitative and qualitative analysis to identify possible causes of out-of-network requests and utilization, and opportunities to improve network adequacy.

Related information

Organizations are required to include CAHPS in their analysis if they submit CAHPS results to NCQA. If an organization is unable to include CAHPS in its analysis because of a small denominator and an inability to report valid rates, or does not meet the 15,000 minimum-enrollment threshold (as noted in the Policies and Procedures), then it is not required to include CAHPS in its analysis report for factor 1.

Examples

***Factor 1:* Requests for and utilization of out-of-network services**

UM reports

- Member/practitioner requests for out-of-network services, including:
  - Urgent concurrent, urgent preservice, nonurgent preservice and post-service requests.
  - Final determinations resulting from these requests (approvals and denials, regardless of reason code).
- For PPO products, organizations may compile and analyze requests and final determinations for in-network level of benefits coverage.

Claims data

- Claims denied with the reason “services available in network” or other out-of-network indicator.
- For PPO products, organizations may compile and analyze claims paid with out-of-network cost sharing applied or at price tiers higher than the lowest cost-sharing level.

Requests for and utilization of out-of-network services (First Survey)

Table 1: Annual out-of-network authorization requests per 1,000 members

	Total OON Requests	Total OON Requests/ 1,000 Members	Approved OON Requests	Approved OON Requests/ 1,000 Members	Denied OON Requests	Denied OON Requests/1,000 Members	Goal Met (<10 OON Requests/1,000 Members)
Commercial/ Exchange PPO	1,590	7.95	1,050	5.25	540	2.70	Y
Medicaid HMO	2,462	12.31	620	3.10	1,842	9.21	N

Table 2: Annual utilization of out-of-network services per 1,000 members

	Total Claims for OON Services	Total OON Claims/1,000 Members	Percentage/ Number of OON Claims Paid at In-Network Level	Percentage of OON Claims Paid at OON Levels	Percentage/ Number of OON Claims Denied	Goal Met (<10 OON Claims/1,000 Members)
Commercial/ Exchange PPO	1,790	8.95	59% (1,050)	39% (700)	2% (40)	Y
Medicaid HMO	658	3.29	94% (620)	No OON Benefit	6% (38)	test

*Quantitative analysis***.** Table 1 includes all approved and denied requests for out-of-network services compiled using authorization data supplied from the UM system on a per 1,000-member basis (total membership of 200,000). The organization met its performance goal of <10 out-of-network requests per 1,000 members for commercial/Exchange PPOs, but not for the Medicaid HMO.

- For commercial/Exchange PPOs, nearly twice as many out-of-network requests were approved as were denied. Most approved requests were in rural areas.
- For the Medicaid HMO, three times as many out-of-network requests were denied as were approved. Most approved requests were for dermatology and ophthalmology.

Claims data were evaluated for actual use of out-of-network services (Table 2), regardless of approval status. Claims were evaluated in three ways: paid at the in-network level, paid at the out-of-network level, denied. The organization met its performance goal of less than 10 out-of-network claims per 1,000 members for the commercial/Exchange PPO and the Medicaid HMO. This appears to demonstrate that authorization review processes are effectively identifying and redirecting out-of-network requests to qualified in-network providers and practitioners.

Qualitative analysis. The QI Program Director and the QI Committee reviewed the data. Analysis revealed gaps in the Medicaid HMO practitioner network for specific specialties and geographic regions. A large percentage of Medicaid HMO requests were for out-of-network dermatology services. Some requests were due to excessive appointment wait times or excessive driving distance, and approvals were allocated in those instances. A large volume of requests were due to personal preference for an out-of-network practitioner. Where services were available in network, those requests were denied.

Analysis of data on paid claims did not reveal additional insights related to the practitioner network.

The commercial/Exchange PPO network is broader than the Medicaid HMO network and does not have the same gaps in specialty care. Most approved requests were for members in rural areas (approved due to driving time); others were for highly specialized services. There were no significant trends by specialty type.

For the commercial/Exchange PPO, members may seek out-of-network services without authorization and coverage is at the lower benefit level. Authorization requests to cover out-of-network services at the in-network level resulted in 59% of out-of-network claims being paid at the in-network level. Of these, 39% were paid at the out-of-network level, either because no authorization was requested or the authorization request was denied. Only 2% of out-of-network claims were denied in full; these were for non-emergency out-of-area services, where no benefit exists. There were no trends in out-of-network claims paid in geographic region or practitioner specialty.

Claims data are supplemented by results of the annual member survey, which has a question about the reasons for using out-of-network practitioners. The primary member-reported reason was preference (practitioner reputation, referred by a friend, convenience to work).

The need to increase Medicaid HMO network resources for dermatology services in rural areas was identified as an opportunity for improvement by the QI Committee, specifically as it relates to the number of available practitioners and access to timely appointments. Increasing member access to telehealth services for dermatology is one solution to address this opportunity, as is improving member knowledge regarding in-network ophthalmologists.

There may be an opportunity in the commercial/Exchange PPO product line/product to recruit practitioners across a variety of specialties. Further analysis will be conducted by the QI Director and QI Committee.

Element B: Opportunities to Improve Access to Behavioral Healthcare Services

The organization annually:

1. **Prioritizes opportunities for improvement identified from analyses of availability, accessibility (NET 3) and member experience accessing the network (ME 3).**
2. **Implements interventions on at least one opportunity, if applicable.**
3. **Measures the effectiveness of the interventions, if applicable.**

Summary of Changes

- This is a new standard and element to the MBHO product.

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:* Prioritizes opportunities**

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 4: ~~CC 3~~: Continued Access to Care (Former CC 3)

The organization monitors the continuity and coordination of care that members receive and takes action, as necessary, to improve continuity and coordination of care across the behavioral healthcare network.

Intent

The organization uses information at its disposal to coordinate care transitions and assures continuity of care upon termination of behavioral healthcare practitioner contracts.

Element A: Notification of Termination

The organization notifies members affected by the termination of a behavioral healthcare practitioner or practice group at least 30 calendar days prior to the effective termination date and helps them select a new practitioner or practice site.

Summary of Changes

- This element was formerly CC 3, Element A.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

100%	80%	50%	20%	0%
~~The organization notifies members at least 30 calendar days prior to the effective termination date~~	~~The organization notifies members less than 30 calendar days prior to the effective termination date~~	~~No scoring option~~	~~The organization has procedures for notifying members, but has not implemented them~~	~~The organization does not have a process for notifying members~~

Met	Partially Met	Not Met
The organization notifies members at least 30 calendar days prior to the effective termination date	No scoring option	The organization does not have a process for notifying members

Data source Documented process, Reports, Materials

Scope of review NCQA reviews:

- The organization's policies and procedures or decision process in place throughout the look-back period, ***and***
- Three reports or materials as evidence that members were notified of practitioner termination throughout the look-back period.

Look-back period *For Initial Surveys:* 6 months.

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.

Even if there were no terminations, the organization must have policies and procedures for notifying members of practitioners' terminations.

Evidence that members were notified of practitioner terminations is not required if the organization had no practitioner terminations. The organization documents that no terminations occurred within the look-back period.

The termination date is the date when a termination becomes effective.

If a practitioner or practice group notifies the organization of termination less than 30 calendar days prior to the effective date, the organization notifies the affected members as soon as possible, but no later than 30 calendar days after receipt of the notification.

All member notifications include:

- The practitioner or group name.
- The effective termination date.
- Procedures for selecting another practitioner or group.

NCQA does not require the organization to notify members of practitioner terminations if members select a practitioner group rather than an individual practitioner.

Distribution of termination notice to members

The organization distributes the notification to members by mail, fax or email, or on its website if it informs members that the information is available on line. The organization mails the notification to members who do not have fax, email or internet access.

Exceptions

None.

Related information

The organization is not required to notify members of practitioner relocations or office closures if the practitioner or office remains available to members as part of the network.

Examples

Methods to identify affected members

- Claims data (e.g., number of visits to a practitioner within a specified period; receipt of periodic preventive care by the same practitioner or practice site).
- Practitioner or practice site medical records.

Element B: Continued Access to Practitioners

Upon the termination of a practitioner's contract, the organization implements policies and procedures that allow members receiving treatment for a chronic or acute behavioral health condition to continue to receive care services through the current period of active treatment or for 90 calendar days, whichever is less.

Summary of Changes

- This element was formerly CC 3, Element B.
- Removed "active course of treatment" from the explanation.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets the requirement~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization does not meet the requirement~~

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, Records or files

Scope of review NCQA reviews:

- The organization's policies and procedures in place throughout the look-back period, ***and***
- Three reports, materials, records or files as evidence that the organization meets the requirements throughout the look-back period.
  - NCQA reviews all reports, materials or records or files if the organization has fewer than three.

Look-back period

For Initial Surveys: 6 months.

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.

The organization has a process for identifying members seen by practitioners and practice groups in its network, and notifies members about the opportunity for continued access. Even if no contracts were discontinued, the organization must have a process for identifying and notifying members.

The organization works with practitioners who are no longer under contract to develop a reasonable transition plan for each member in active treatment.

An active course of treatment is when a member has regular visits with the practitioner to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment protocol. Active treatment does not include routine monitoring for a chronic condition (e.g., monitoring chronic depression, not for an acute phase of the condition).

This element applies if the practitioner agrees to:

- Continue treatment for an appropriate period of time (based on transition plan goals).
- Share information about the treatment plan with the organization.
- Continue to follow the organization's UM policies and procedures.
- Charge only the required copayment.

Exceptions

The organization is not required to provide continued access if:

- The practitioner is unwilling to continue to treat the member or accept the organization's payment or other terms.
- The member is assigned to a practitioner group, rather than to an individual practitioner, and has continued access to practitioners in the contracted group.
- The organization discontinued a contract based on a professional review action, as defined in the Health Care Quality Improvement Act of 1986 (as amended, 42 U.S.C. section 11101 et seq.).

Examples

Documentation

- Letters to members showing continued access.
- UM cases showing continued access.
- Paid claims showing continued access.
- Case management records showing continued access.
- Report regarding a terminated practitioner, stating why continued access does not apply.
- Contracts with practitioners include continued access for the periods specified in the requirement.

Element C: Care Transitions

The organization helps with members' transition to other care when their benefits end, if necessary.

Summary of Changes

- This element was formerly CC 3, Element C.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets the requirement~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization does not meet the requirement~~

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, Records or files

Scope of review

NCQA reviews a documented process and three examples (i.e., reports, materials, records or files) of how the requirement is met. Evidence demonstrates that the organization helped members transition to other care, as needed, throughout the look-back period. If the organization has fewer than three examples, NCQA reviews all reports, materials, records or files.

Look-back period

For Initial Surveys: 6 months.

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.

Exhausted benefits

If the organization's covered benefits are exhausted while a member continues to need care, the organization must notify the member about alternatives for continuing care and how to obtain care, as appropriate.

NCQA does not expect the organization to develop alternative resources, only to notify members of available resources.

Exceptions

None.

Related information

Identifying members whose benefits are exhausted. The organization may identify qualified individuals using daily case manager reports or requests for extension of needed services that were denied due to benefit limitations.

Examples

Excerpt from member letter implementing transition of care

…Your doctor has requested that we extend your inpatient behavioral healthcare

coverage for an additional 8 days. Our records indicate that you will exhaust your benefit on [date], which is 10 days before your treatment is complete.

There are several alternative resources for care available to you through local and state-funded agencies. We have included a list of them and their contact information.

NET 5: ~~RR4:~~ Practitioner and Provider Directories (Former RR 4)

The organization provides information to help members and prospective members choose behavioral health care practitioners and providers.

Intent

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

Element A: Practitioner Directory Data

The organization has a web-based practitioner directory that <u>includes</u> <u>search capabilities for the following practitioner information:</u>

1. **Name.**
2. **Gender.**
3. **Discipline/provider type.**
4. **Specialty.**
5. **Organizational affiliations.**
6. **Board certification.**
7. **Accepting new patients.**
8. **Languages spoken by the practitioner or the staff.**
9. **Office locations and phone numbers.**

Summary of Changes

- This element was formerly RR 4, Element A.
- Revised the factor 4 explanation to clarify directory contents.
- Revised the factor 9 explanation to clarify practitioner information.
- <u>Adjusted scoring to "Met," "Partially Met" and "Not Met."</u>

<u>Scoring</u>

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 7-9 factors~~	~~The organization meets 5-6 factors~~	~~The organization meets 4 factors~~	~~The organization meets 2-3 factors~~	~~The organization meets 0-1 factors~~

<u>Met</u>	<u>Partially Met</u>	<u>Not Met</u>
<u>The organization meets 5-9 factors</u>	<u>The organization meets 4 factors</u>	<u>The organization meets 0-3 factors</u>

Data source Materials

Scope of review 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 Initial Surveys:* 6 months.

For Renewal Surveys: 24 months.

Explanation This requirement applies only to network practitioners.

Every field must be populated. If a factor does not apply to a practitioner, the data field indicates "None" or "NA."
The directory must include all practitioners who fall under the scope of credentialing defined in CR 1, Element A, with the following exceptions:

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

Factors 1–3

No additional explanation required.

***Factor 4:* Specialty**

The directory lists:

- All applicable specialties, for practitioners.
- All applicable disciplines, for contracted behavioral healthcare practitioners.

~~The directory is not required to list subspecialty.~~

The directory lists a subspecialty, area of expertise, or focus for practitioners.

***Factor 5:* Organizational affiliations**

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

***Factor 6:* Board certification**

The directory lists practitioners' board certification.

For physicians who are board certified, the directory lists board certification from ABMS or AOA, *and* provides:

- A link directly to ABMS or AOA to verify current status, ***or***
- Instructions on how to check the most current board certification status by going to the ABMS or AOA website.

For nonphysician practitioners who are board certified, the directory lists board certification from an appropriate specialty board, *and* provides:

- A link directly to the appropriate specialty board to verify current status, ***or***
- Instructions on how to check the most current board certification status by going to the website of the appropriate specialty board.

***Factor 7:* Accepting new patients**

The directory indicates whether behavioral healthcare practitioners are accepting new patients.

Factor 8: **Languages spoken by the practitioner or staff**

The directory may list languages spoken by the office 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 number**

The directory lists the physical addresses and phone numbers of office locations where practitioners practice. If a practitioner 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

Factor 6 is NA for practitioners who are not board certified.

Examples None.

Element B: Practitioner Directory Updates

The organization updates its web-based practitioner directory within 30 calendar days of receiving new information from a practitioner.

Summary of Changes

- This element was formerly RR 4, Element B.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets the requirement~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization does not meet the requirement~~

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 NCQA reviews:

- The organization's policies and procedures in place throughout the look-back period that states the frequency of updates, ***and***
- Three reports or materials as evidence that the directory was updated within 30 calendar days of receipt of new information.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

This requirement applies only to network practitioners.

Exceptions

None.

Examples

None.

Element C: Assessment of Practitioner Directory Accuracy

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

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

Summary of Changes

- This element was formerly RR 4, Element C.
- Revised the element language and requirements from annual evaluation to "at least every 6 months."
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 3 factors~~	~~The organization meets 2 factors~~	~~No scoring option~~	~~The organization meets 1 factor~~	~~The organization meets 0 factors~~

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

Data source

Reports

Scope of review

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

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

Look-back period

For Initial Surveys: At least once during within the past 6 months.~~the prior year.~~

For Renewal Surveys: 24 months.

Explanation

Factors 1–2: **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 practitioner directories for factors 1–2 is correct. The organization may include its entire practitioner 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 practitioner directories. If the organization collects information from surveys, its methodology description includes the process for practitioner 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 5: Glossary* for the full definition of and requirements for qualitative analysis.

Factor 3: **Awareness of practitioner participation in the organization's networks**

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

The organization assesses whether network practitioner office staff can identify all products/product lines and networks in which practitioners participates.

Exception

Factor 3 is NA for integrated HMO models (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 practitioner directories. It drew a single, representative sample of primary care practitioners and specialists across its networks using a 95% confidence level and a 5% confidence interval (margin of error).

For factors 1–2, 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 practitioner information over time. If the provider's survey response matched the information published in its web directory, the information was considered accurate.

For factor 3, the organization conducted telephone surveys on practices selected in the sample and compared its directory information to information in its practitioner contracts.

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

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

Denominator: Number of practitioner offices in the sample.

Office Location/ Phone Numbers	Practitioners	
	Commercial	Medicaid

Numerator	90	75
Denominator	120	87
Rate	75%	86%

Factor 2: **Accepting new patients**

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

Denominator: Number of practitioner offices in the sample.

Accepting New Patients	Practitioners	
	Commercial	Medicaid
Numerator	97	82
Denominator	120	87
Rate	81%	94%

Factor 3: **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 practitioner offices in the sample.

Active Network Contracts	Practitioners	
	Commercial	Medicaid
Numerator	100	76
Denominator	120	87
Rate	83%	87%

Element D: Identifying and Acting on Opportunities

Based on results of the analysis performed in Element C, at least annually, the organization:

1. **Identifies opportunities to improve the accuracy of the information in its practitioner directories.**
2. **Takes action to improve the accuracy of the information in its practitioner directories.**

Summary of Changes

- This element is former RR 4, Element D.
- Removed the exception for this element.
- Adjusted scoring to “Met,” “Partially Met” and “Not Met.”

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization~~

~~meets 2 factors~~				~~meets 0-1 factors~~

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

Data source Documented process, Reports

Scope of review

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

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

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

Look-back period

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

For Renewal Surveys: 24 months.

Explanation

***Factor 1*: Identifying opportunities**

The organization identifies opportunities to pursue from the qualitative analysis performed in Element C. The identified opportunities relate directly to the findings of the qualitative analysis.

***Factor 2*: Acting on opportunities**

The organization demonstrates that it has acted to improve the accuracy of its practitioner directories.

The organization takes at least one action to improve the accuracy of information in its practitioner directories. Actions relate directly to the cause of the deficiency identified in the qualitative analysis.

Exception

Factor 2 is NA if the organization has no opportunities for improvement. NCQA evaluates whether this conclusion is reasonable, given assessment results.

Examples None.

~~Element E: Searchable Practitioner Web-Based Directory~~

~~The organization's web-based practitioner directory includes search functions with instructions on how to find the following practitioner information:~~

~~1. Name.~~

~~2. Gender.~~

3. Discipline/provider type.

4. Specialty.

5. Accepting new patients.

6. Languages spoken by the practitioner and or the staff.

7. Office locations.

Summary of Changes

- No changes to this element.

Scoring

100%	80%	50%	20%	0%
The organization meets 7 factors	The organization meets 5-6 factors	The organization meets 4 factors	The organization meets 2-3 factors	The organization meets 0-1 factors

Data source Materials

Scope of review 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 Initial Surveys:* 6 months.

For Renewal Surveys: 24 months.

Explanation This requirement applies only to network practitioners.

Factors 1–7: **Practitioner directory data**

The directory:

- Allows customized searches based on the information most relevant for members, ***or***
- Allows searches by each field or by ZIP code and specialty, and contains:
  - An advanced-search option using multiple variables required in factors 1–7.
  - Instructions on using the advanced-search function and a direct link to the function.

Exception

Factors marked "No" in Element A are scored NA in this element.

Examples None.

Element F: Provider Directory Data

The organization has a web-based provider directory that <u>includes search capabilities</u> for the following information to help members and prospective members choose a provider:

1. Facility name.

<u>2. Facility type.</u>

3. Facility location and phone number.

4. Facility accreditation status.

Summary of Changes

- This element was formerly RR 4, Element F.
- Revised the element language and requirements to include "search capabilities.
- Added factor 4, facility type.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 3 factors~~	~~The organization meets 2 factors~~	~~The organization meets 1 factor~~	~~No scoring option~~	~~The organization meets 0 factors~~

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

Data source Materials

Scope of review
Look-back period

NCQA reviews the organization's web-based directory or screenshots of its web-based directory that is in place throughout the look-back period.
For Initial Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

This requirement applies only to network providers.

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

Factor 1: **Facility name**

No additional explanation required.

Factor 2: **Facility type**

The directory lists the facility type.

Factor 3: **Facility location and phone number**

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

Factor 4: **Facility accreditation status**

The directory indicates:

- Whether the facility is accredited.
  - If the facility is accredited, the field specifies the accrediting organization (e.g., The Joint Commission, Commission on Accreditation of Rehabilitation Facilities, Accreditation Commission for Health Care).
- The facility's accreditation status.

- A link to the accrediting organization's site displaying the accreditation status meets factor 4.
- A link to an accrediting organization's general website does not meet factor 4.

Exceptions

None.

Related information

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

Examples None.

Element G: Provider Directory Updates

The organization updates its web-based provider directory information within 30 calendar days of receiving new information from the provider.

Summary of Changes

- This element was formerly RR 4, Element G.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets the requirement~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization does not meet the requirement~~

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 NCQA reviews:

- The organization's policies and procedures in place throughout the look-back period that states the frequency of updates, ***and***
- Three reports or materials as evidence showing that the directory was updated within 30 calendar days of receipt of new information.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 24 months.

Explanation This requirement applies only to network providers.

Exceptions

None.

Examples None.

~~Element H: Searchable Provider Web-Based Directory~~

~~The organization's web-based directory includes search functions for specific data types and instructions for searching the following information:~~

~~1. Facility name.~~

~~2. Facility location.~~

~~Summary of Changes~~

- ~~No changes to this element.~~

~~Scoring~~

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 2 factors~~	~~No scoring option~~	~~The organization meets 1 factor~~	~~No scoring option~~	~~The organization meets 0 factors~~

~~Data source~~ ~~Materials~~

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

~~Look-back period~~ ~~*For Initial Surveys:* 6 months.~~

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

~~Explanation~~ ~~This requirement applies only to network providers.~~

~~The provider directory:~~

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

~~Factors 1, 2~~

~~No additional explanation required.~~

~~Exception~~

~~Factors marked "No" in Element F are scored NA in this element.~~

~~Examples~~ ~~None.~~

Element I: Usability Testing

The organization evaluates its web-based practitioner and provider 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

- This element was formerly RR 4, Element I.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 4 factors~~	~~The organization meets 3 factors~~	~~The organization meets 2 factors~~	~~The organization meets 1 factor~~	~~The organization meets 0 factors~~

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 NCQA reviews the organization's policies and procedures and evidence that it conducted usability testing.

Look-back period *For Initial 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 practitioner and provider directories meets the intent.

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

evaluates the vendor's documentation against the requirements. Refer to *Vendors* in*: Delegation and Automatic Credit Guidelines.*

Examples None.

Element J: Availability of Directories

The organization makes web-based practitioner and provider directory information available to members and prospective members through alternative media, including:

1. **Print.**
2. **Telephone.**

Summary of Changes

- This element was formerly RR 4, Element J.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 2 factors~~	~~No scoring option~~	~~The organization meets 1 factor~~	~~No scoring option~~	~~The organization meets 0 factors~~

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

Data source Documented process, Materials

Scope of review NCQA reviews the organization's policies and procedures for making the directories available, other evidence (e.g., scripts for telephone directories, printed screenshots of screens accessed during calls) and a printed sample of the directories available throughout the look-back period.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 24 months.

Explanation ***Factors 1, 2***

The print and telephone directories include the same information available in the web-based practitioner and provider directories.

Exceptions

None.

Examples None.

NET 6: Delegation of NET

If the organization delegates NCQA-required network management 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 network management activities.

Element A: Delegation Agreement

The written delegation agreement:

1. **Is mutually agreed upon.**
2. **Describes the delegated activities and the responsibilities of the organization and the delegated entity.**
3. **Requires at least semiannual reporting by the delegated entity to the organization.**
4. **Describes the process by which the organization evaluates the delegated entity's performance.**
5. **Describes the process for providing member experience and clinical performance data to its delegates when requested.**
6. **Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.**

Summary of Changes

- This is a new standard and element to the MBHO product.

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 Materials

Scope of review

Product lines

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

Documentation

NCQA reviews delegation agreements in effect during the look-back period from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

Delegation agreements implemented on or after January 1, 2019, must include a description of the process required in factor 5.

For delegation agreements in place prior to January 1, 2019, the organization may provide documentation that it notified the delegate of the process required in factor 5. This documentation of notification is not required to be mutually agreed upon.

The score for the element is the average of the scores for all delegates.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

This element may not be delegated.

This element applies to agreements that are in effect within the look-back period.

The delegation agreement describes all delegated NET activities. A generic policy statement about the content of delegated arrangements does not meet this element.

***Factor 1:* Mutual agreement**

Delegation activities are mutually agreed on before delegation begins, in a dated, binding document or communication between the organization and the delegated entity.

NCQA considers the effective date specified in the delegation agreement as the mutually agreed-upon effective date. The effective date may be before or after the signature date on the agreement. If the agreement has no effective date, NCQA considers the signature date (meaning the date of last signature) as the mutually agreed upon effective date.

NCQA may accept other evidence of the mutually agreed-upon effective date: a letter, meeting minutes or other form of communication between the organization and the delegate that references the parties' agreement on the effective date of delegated activities.

NCQA requires submitted evidence for all other delegation factors to consider the same mutually agreed-upon date as the effective date for the delegate's performance of delegated activities.

***Factor 2:* Assigning responsibilities**

The delegation agreement or an addendum thereto or other binding communication between the organization and the delegate specifies the NET activities:

- Performed by the delegate in detailed language.
- Not delegated, but retained by the organization.
  - The organization may include a general statement in the agreement addressing retained functions (e.g., the organization retains all other NET functions not specified in this agreement as the delegate's responsibility).

If the delegate subdelegates an activity, the delegation agreement must specify that the delegate or organization is responsible for subdelegate oversight.

***Factor 3:* Reporting**

The organization determines the method of reporting and the content of the reports, but the agreement must specify:

- That reporting is at least semiannual.
- What information is reported by the delegate about delegated activities.
- How, and to whom, information is reported (i.e., joint meetings or to appropriate committees or individuals in the organization).

The organization must receive regular reports from all delegates, even NCQA-Accredited or NCQA-Certified delegates.

***Factor 4:* Performance monitoring**

The delegation agreement specifies how the organization evaluates the delegate's performance.

***Factor 5:* Providing member and clinical data**

The organization's delegation agreement describes what the delegate must do to obtain the following data when it is needed or on an ongoing basis:

- *Member experience data:* Complaints, CAHPS survey results or other data collected on members' experience with the delegate's services.
- *Clinical performance data:* HEDIS measures, claims and other clinical data collected by the organization. The organization may provide data feeds for relevant claims data or clinical performance measure results.

***Factor 6:* Consequences for failure to perform**

The delegation agreement specifies consequences if a delegate fails to meet the terms of the agreement and, at a minimum, circumstances that would cause revocation of the agreement.

Exceptions

This element is NA if the organization does not delegate NET activities.

Factor 5 is NA for mail service organization delegates.

The clinical performance aspect of factor 5 is NA if clinical performance data are not relevant to the delegated activities.

Examples None.

Element B: Predelegation Evaluation

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Summary of Changes

- This is a new standard and element to the MBHO product.

Scoring

Met	Partially Met	Not Met
The organization evaluated delegate capacity before delegation began	The organization evaluated delegate capacity after delegation began	The organization did not evaluate delegate capacity

Data source Reports

Scope of review

Product lines

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

This element applies if delegation was implemented in the look-back period.

Documentation

NCQA reviews the organization's predelegation evaluation from up to four randomly selected delegates, or reviewed all delegates if the organization has fewer than four.

The score for the element is the average of the scores for all delegates.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

This element may not be delegated.

NCQA-Accredited/Certified delegates

Automatic credit is available for this element if all delegates are NCQA-Accredited health plans, MBHOs, NCQA-Certified HIP organizations or NCQA-Accredited PN organizations, unless the element is NA. NCQA-Certified HIPs must be certified in the activity being delegated by the organization.

Note: For organizations that have both NCQA-Accredited/Certified and non-Accredited/Certified delegates:

- *NCQA-Accredited/Certified delegates are eligible for automatic credit.*
- *Non-Accredited/Certified delegates are reviewed and scored accordingly.*

Predelegation evaluation

The organization evaluated the delegate's capacity to meet NCQA requirements within 12 months prior to implementing delegation. The evaluation may include a review of the organization's structure, processes, and staffing in order to determine its capability to perform the delegated function.

NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date.

If the time between the predelegation evaluation and implementation of delegation exceeds the 12 months, the organization conducts another predelegation evaluation.

If the organization amends the delegation agreement to include additional NET activities within the look-back period, it performs a predelegation evaluation for the additional activities.

Exceptions

This element is NA if:

- The organization does not delegate NET activities.
- Delegation arrangements have been in effect for longer than the look-back period.

Related information

Use of collaboratives. An organization may collaborate in a statewide, predelegation evaluation with other organizations that have overlapping practitioner and provider networks. The organizations in the collaborative use the same audit tool and share data.

Examples

Predelegation evaluation

- Site visit.
- Telephone consultation.
- Documentation review.
- Committee meetings.
- Virtual review.

Element C: Review of Delegated Activities

For arrangements in effect for 12 months or longer, the organization:

1. **Annually reviews its delegate's network management procedures.**
2. **Annually evaluates delegate performance against NCQA standards for delegated activities.**
3. **Semiannually evaluates regular reports, as specified in Element A.**

Summary of Changes

- This is a new standard and element to the MBHO product.

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 for all product lines.

Documentation

NCQA reviews evidence of the organization's review from up to four randomly selected delegates, or all delegates if the organization has fewer than four.

For First Surveys: NCQA reviews the organization's most recent annual review, performance evaluation and semiannual evaluation.

For Renewal Surveys: NCQA reviews the organization's most recent and the previous year's annual reviews, performance evaluations and four semiannual evaluations.

The score for the element is the average of the scores for all delegates.

Look-back period

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

For Renewal Surveys: 24 months.

Explanation

This element may not be delegated.

NCQA-Accredited/Certified delegates

Automatic credit is available for factor 2 if all delegates are NCQA-Accredited health plans, MBHOs, NCQA-Certified HIPs or NCQA-Accredited PN organizations, unless the element is NA. NCQA-Certified HIPs must be certified in the activity being delegated by the organization.

Note: *For organizations that have both NCQA-Accredited/Certified and non-Accredited/Certified delegates:*

- *NCQA-Accredited/Certified delegates are eligible for automatic credit.*
- *Non-Accredited/Certified delegates are reviewed and scored accordingly.*

Factor 1: **Review of the delegate's network management procedures**

Appropriate organization staff or committee reviews the delegate's network management procedures. At a minimum, the organization reviews parts of the network management program that apply to the delegated functions.

Factors 2, 3

No additional explanation required.

Exceptions

This element is NA if:

- The organization does not delegate NET activities.
- Delegation arrangements have been in effect for less than 12 months.

Factor 1 is NA:

- If the organization only delegates directory functions.
- For mail service delegates.

Examples None.

Element D: Opportunities for Improvement

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.

Summary of Changes

- This is a new standard and element to the MBHO product.

Scoring

Met	Partially Met	Not Met
The organization has acted on identified problems, if any, at least once in each of the past 2 years that the delegation arrangement has been in effect	The organization took inappropriate or weak action, or acted only in the past year	The organization has not acted on identified problems

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

NCQA reviews reports of opportunities for improvement, if applicable, from up to four randomly selected delegates, or from all delegates, if the organization has fewer than four, and for evidence that the organization took appropriate action to resolve issues.

For First Surveys: NCQA reviews the organization's most recent annual review and follow-up on improvement opportunities.

For Renewal Surveys: NCQA reviews the organization's most recent and previous year's annual reviews and follow-up on improvement opportunities.

The score for the element is the average of the scores for all delegates.

Look-back period

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

For Renewal Surveys: 24 months.

Explanation

This element may not be delegated.

NCQA-Accredited/Certified delegates

Automatic credit is available for this element if all delegates are NCQA-Accredited health plans, MBHOs, NCQA-Certified HIP organizations or NCQA-Accredited PN organizations, unless the element is NA. NCQA-Certified HIPs must be certified in the activity being delegated by the organization.

Note: *For organizations that have both NCQA-Accredited/Certified and non-Accredited/Certified delegates:*

- *NCQA-Accredited/Certified delegates are eligible for automatic credit.*
- *Non-Accredited/Certified delegates are reviewed and scored accordingly.*

Identify and follow-up on opportunities

The organization uses information from its predelegation evaluation, ongoing reports, or annual evaluation to identify areas of improvement, if any.

Exceptions

This element is NA if:

- The organization does not delegate NET activities.
- Delegation arrangements have been in effect for less than 12 months.
- The organization has no opportunities to improve performance.
  - NCQA evaluates whether this conclusion is reasonable, given assessment results.

Examples

None.

Utilization Management

UM 1: Utilization Management 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 the following:

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

Summary of Changes

- ~~No changes to this element.~~
- Added factors 3 and 4.
- <u>Adjusted scoring to "Met," "Partially Met" and "Not Met."</u>

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 3 factors~~	~~The organization meets 2 factors~~	~~No scoring option~~	~~The organization meets 1 factor~~	~~The organization meets 0 factors~~

<u>Met</u>	<u>Partially Met</u>	<u>Not Met</u>
<u>The organization meets 4-5 factors</u>	<u>The organization meets 2-3 factors</u>	<u>The organization meets 0-1 factor</u>

Data source Documented process, Reports

Scope of review NCQA reviews the organization's UM <u>written</u> program description.

~~*For factor 2,* NCQA also reviews three UM Committee meeting minutes or other reports documenting active involvement of 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 Initial Surveys:* 6 months.

For Renewal Surveys: 24 months for factors <u>1, 2 and 5; prior to the survey date for factors 3 and 4.</u>

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.

The UM program description is organized and written so staff members and others can understand the program's structure, scope and processes, and the sources of information 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 process 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.
- 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 when they may be 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 circumstance. 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 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*.

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 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.

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 if:

- They have financial liability (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; however, the case is considered a denial if a denial notice was issued.

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

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.

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 assigned activities.
- UM staff ~~who have~~ with the authority to deny coverage.
- Involvement of 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: **Designated behavioral healthcare practitioner involvement**

The program description specifies how a designated behavioral healthcare practitioner is actively involved in the organization's UM Committee, ~~UM activities,~~ including implementation, supervision, oversight and evaluation 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 or participating practitioner.

NEW Factor 3: **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 4: **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.

Factor 3: **Processes and information sources used to make determinations**

The program description specifies:

- The 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 triage and referral process for behavioral healthcare services.
- How service sites and levels of care for behavioral healthcare services are evaluated.

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

Exceptions

None.

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 2: **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.

Scoring

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.

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 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. 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.

Element B: Annual Evaluation

The organization annually evaluates and updates the UM program, as necessary.

Summary of Changes

- No changes to this element.

Scoring

100%	80%	50%	20%	0%
The organization meets the requirement	No scoring option	No scoring option	No scoring option	The organization does not meet the requirement

Data source Documented process, Reports

Scope of review *For Initial Surveys:* NCQA reviews the organization's most recent annual evaluation report and updates, if applicable.

For Renewal Surveys: NCQA reviews the organization's most recent and previous year's annual evaluation reports and updates, if applicable.

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.

To determine if its UM program remains current and appropriate, the organization annually evaluates:

- The program structure.
- The program scope, processes and information sources used to determine benefit coverage and medical necessity.
- The level of involvement of the senior-level physician and designated behavioral healthcare practitioner in the UM program.

The organization considers member and practitioner experience data when evaluating its UM program, and updates the UM program based on its evaluation.

Exceptions

None.

Examples None.

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 clinical 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.**

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 5 factors~~	~~The organization meets 4 factors~~	~~The organization meets 3 factors~~	~~The organization meets 2 factors~~	~~The organization meets 0-1 factors~~

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

Scope of review NCQA reviews:

- *For factors 1–3:* The organization's policies and procedures in place throughout the look-back period.
- *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 the most recent and previous year's annual reviews and updates (for *Renewal Surveys*).

Look-back *For Initial Surveys:* 6 months for factors 1–4; at least once during the prior year for

period 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 care, 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 are provided ~~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.

***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.

Exception

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 highly specialized services, such as detoxification facilities.
- Availability of partial hospitalization and other step-down services 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 Criteria

The organization <u>makes UM criteria available to practitioners at the point of care</u>:

1. ~~**States in writing how practitioners can obtain UM criteria.**~~
2. ~~**Makes the criteria available to its practitioners upon request.**~~

Summary of Changes

- ~~No changes to this element.~~
- <u>Adjusted scoring to "Met," "Partially Met" and "Not Met."</u>

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The~~	~~No scoring~~	~~The~~	~~No scoring~~	~~The~~

~~organization meets 2 factors~~	~~option~~	~~organization meets 1 factor~~	~~option~~	~~organization meets 0 factors~~

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
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 methods listed above or through ~~either~~ anyof the following methods:

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

Exception

~~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.**

Summary of Changes

- ~~No changes to this element.~~
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

~~Scoring~~

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 2 factors~~	~~No scoring option~~	~~The organization meets 1 factor~~	~~No scoring option~~	~~The organization meets 0 factors~~

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

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 Initial 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. Any referral that requires prior approval is considered a UM determination.

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 https://www.ncqa.org/programs/health-plans/policy-accreditation-and-certification, ***or***
    - Another statistically valid method.

Factor 2: **Act on opportunities**

No additional explanation required.

Exception

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

Member 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 are available to receive inbound communication regarding UM issues after normal business hours.**
3. **Staff are identified by name, title and organization when they initiate or return calls regarding UM issues.**
4. **TDD/TTY services for deaf, hard of hearing or speech impaired members.**
5. **Language assistance for members to discuss UM issues.**
6. **Member navigation assistance with denials, appeals or UM questions.**

Summary of Changes

- ~~No changes to this element.~~
- Added factor 6.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 5 factors~~	~~The organization meets 4 factors~~	~~The organization meets 3 factors~~	~~The organization meets 1-2 factors~~	~~The organization meets 0 factors~~

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 *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.

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 Initial Surveys: 6 months.

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

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.

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.

Exceptions

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 4: Appropriate Professionals

Qualified licensed health professionals assess the clinical information used to support UM decisions.

Intent

UM decisions are made by qualified health professionals.

Element A: Licensed Health Professionals

The organization has written procedures:

1. **Requiring appropriately licensed behavioral healthcare professionals to supervise all medical necessity decisions.**
2. **Specifying the type of personnel responsible for each level of UM decision making.**

Summary of Changes

- ~~No changes to this element.~~
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 2 factors~~	~~No scoring option~~	~~The organization meets 1 factor~~	~~No scoring option~~	~~The organization meets 0 factors~~

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

Data source Documented process

Scope of review NCQA reviews the organization's policies and procedures.

Look-back period *For Initial Surveys:* 6 months.

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: **Supervision**

The policies and procedures specify that the organization uses licensed health care professionals to supervise UM activities. These licensed health care professionals:

- Provide day-to-day supervision of assigned UM staff.
- Participate in staff training.
- Monitor for consistent application of UM criteria by UM staff, for each level and type of UM decision.
- Monitor documentation for adequacy.
- Are available to UM staff on site or by telephone.

Factor 2: **UM personnel and appropriate practitioners**

The policies and procedures specify that the organization uses licensed health care professionals to make UM decisions that require clinical judgment.

The following staff may approve services:

- Staff who are not qualified health care professionals and are under the supervision of appropriately licensed health professionals, when there are explicit UM criteria and no clinical judgment is required.
- Licensed health care professionals.

Exceptions

None.

Related information

UM oversight. As specified in *UM 1: Program Structure,* Element A, a senior-level behavioral healthcare practitioner is involved in the behavioral health aspects of the UM program. This individual is not required to have day-to-day involvement in UM activities.

For doctoral-level clinical psychologists, such authority must be in the scope of their license to practice.

Examples None.

Element B: Use of Practitioners for UM Decisions

The organization has a written job description with qualifications for behavioral healthcare practitioners who review denials of care based on medical necessity. Practitioners are required to have:

1. **Education, training or professional experience in medical or clinical practice.**
2. **A current clinical license to practice or an administrative license to review UM cases.**

Summary of Changes

- Adjusted scoring to “Met,” “Partially Met” and “Not Met.”

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The description includes 2 factors for all appropriate practitioners~~	~~No scoring option~~	~~The description includes 1 factor for all appropriate practitioners~~	~~The description includes 1-2 factors for some appropriate practitioners~~	~~The description includes 0 factors~~

Met	Partially Met	Not Met
The description includes 2 factors for all appropriate practitioners	The description includes 1 factor for all appropriate practitioners	The description includes 0 factors

Data source Materials

Scope of review NCQA reviews practitioners' job descriptions in place throughout the look-back period.

Look-back period *For Initial Surveys:* 6 months.

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.

The written description applies to all types of practitioners who may review denials of care based on medical necessity for the organization. NCQA considers the following practitioner types to be appropriate for review of the specified UM denial decisions:

- *Physicians, all types:* Medical, behavioral healthcare and pharmaceutical denials.
- *Nurse practitioners*:* Medical, behavioral healthcare, pharmaceutical, dental, chiropractic and vision denials.
- *Doctoral-level clinical psychologists or certified addiction-medicine specialists:* Behavioral healthcare denials.
- *Pharmacists:* Pharmaceutical denials.
- *Doctoral-level board-certified behavioral analysts:* Applied behavioral analysis denials.

* *In states where the organization has determined that practice acts or regulations allow nurse practitioners to practice independently, these practitioners may review requests that are within the scope of their license.*

Factor 1: **Education, training or professional experience**

No additional explanation required.

Factor 2: **Current clinical or administrative license**

An administrative license is a limited license that allows practitioners to use clinical skills and knowledge to make judgment on the medical or clinical appropriateness of requested care or services, but does not convey the authority to practice clinical medicine or to prescribe medications.

Exceptions

None.

Examples None.

Element C: Practitioner Review of Denials

The organization uses a physician or appropriate behavioral health practitioner to review any behavioral healthcare denial based on medical necessity.

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review~~	~~No scoring option~~	~~Medium (60-89%) on file review~~	~~No scoring option~~	~~Low (0-59%) on file review~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review NCQA reviews a random sample of up to 40 UM denial files resulting from medical necessity review for evidence that the files were reviewed by an appropriate practitioner.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 12 months.

Explanation **THIS IS A MUST-PASS ELEMENT.**

This element applies to all UM 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.

Appropriate practitioner review

Appropriate practitioners review all medical necessity denials for requested health care services offered under the organization's behavioral healthcare benefit. NCQA does not require appropriate practitioner review of requests for medical services that are specifically excluded from the benefits plan or that exceed the limitations or restrictions stated in the benefits plan.

The UM denial file includes any of the following documentation of appropriate

professional review:

- The reviewer's handwritten signature or initials.
- The reviewer's unique electronic signature or identifier on the denial letter or on the notation of denial in the file.
- A signed or initialed note from UM staff, attributing the denial decision to the professional who reviewed and decided the case.

Exceptions

None.

Related information

UM denial file exclusions. NCQA does not include the following UM decisions in the UM denial file sample:

- UM decisions that do not require medical necessity review.
- UM approvals, including substitution of a generic pharmaceutical for a name-brand pharmaceutical.
- Pharmacy benefit denials resulting from closed formularies and related to tiered formularies, copayments, generic substitution and therapeutic interchange.

Examples None.

Element D: Use of Licensed Consultants

The organization:

1. **Has written procedures for using licensed consultants to assist in making medical necessity determinations.**
2. **Provides evidence that it uses licensed consultants for medical necessity determinations.***

Critical factors: Score cannot exceed 0% if one critical factor is scored "No."

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 2 factors~~	~~No scoring option~~	~~The organization meets factor 2 only~~	~~No scoring option~~	~~The organization meets factor 1 only or meets 0 factors~~

Met	Partially Met	Not Met
The organization meets 2 factors	The organization meets factor 2 only	The organization meets factor 1 only, or meets 0 factors

Data source Documented process, Reports, Materials, Records or files

Scope of review

For All Surveys:

- *For factor 1*, NCQA reviews the organization's written policies and procedures for using internal and external licensed consultants, and reviews

the list of licensed consultants.

- *For factor 2*, NCQA also reviews three cases showing the use of external licensed consultants during the look-back period. If there are not three cases showing the use of external consultants, NCQA also reviews internal cases, for a total of three cases. If the organization does not use external licensed consultants, NCQA reviews three cases showing the use of internal consultants.

Look-back period

For Initial Surveys: 6 months.

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.

Factor 2 is a critical factor; if this critical factor is scored "No," the organization's score cannot exceed "0%" for the element.

This element applies to medical necessity determinations.

Factor 1: **Policies and procedures for using licensed consultants**

The organization has written policies and procedures for using internal and external licensed consultants. The organization maintains a list of licensed consultants that includes contact information (e.g., phone numbers, names, specialties), and makes the list available to UM staff as a reference for contacting those consultants.

If external entities are unable to provide a list of all licensed certified consultants, for proprietary reasons, they may provide a list of the specialties of all licensed consultants, with contact information; a name is not required. Listing an external entity's centralized contact information meets the intent if the entity does not provide direct contact information for individual specialists, but all available specialist types must be included on the organization's list.

Factor 2: **Evidence of use of licensed consultants**

NCQA reviews three cases showing the use of external licensed consultants for medical necessity determinations. If the organization does not have three cases using external licensed consultants, NCQA also reviews cases of using internal consultants, for a total of three cases.

If the organization does not use external consultants for medical necessity determinations because all specialties are available in the organization, NCQA reviews three cases of the use of internal consultants. Network practitioners are not considered part of the organization.

Exceptions

None.

Related information

NCQA does not consider it delegation if a licensed consultant reviews cases and makes a recommendation for medical necessity determinations, if the organization makes the final decision. If the consultant makes the final decision, NCQA considers this to be delegation.

Examples

None.

UM 5: Timeliness of UM Decisions

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

Intent

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

Element A: Notification of Decisions

The organization adheres to the following time frames for notification of UM decision making:

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.**~~
5. ~~4~~**. For postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 30 calendar days of the request.**

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review~~	~~No scoring option~~	~~Medium (60-89%) on file review~~	~~No scoring option~~	~~Low (0-59%) on file review~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review NCQA reviews a random sample of up to 40 UM denial files resulting from medical necessity review for evidence of timeliness of notification.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 12 months.

Explanation **THIS IS A MUST-PASS ELEMENT.**

This element applies to all UM 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 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 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 care or services that the organization must approve in advance, in whole or in part.

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

Reclassification of 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 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 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 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 timeframes to the practitioner were appropriate.

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).

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 time frame for urgent, preservice and postservice requests.

Extension conditions

Factors 1, 2: Urgent concurrent and urgent preservice requests for	*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***

Medicare and Medicaid product lines.

- 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.

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: UM Timeliness Report~~

~~**The organization monitors and submits a report for timeliness of notification of UM decisions.**~~

Summary of Changes

- No changes to this element.

Scoring

100%	80%	50%	20%	0%
The organization meets the requirement	No scoring option	No scoring option	No scoring option	The organization does not meet the requirement

Data source Reports

Scope of review NCQA reviews the organization's aggregated timeliness reports.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 12 months.

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

The organization monitors the timeliness of notification for all requests and, using at least 6 months of data, calculates the percentage of decisions that adhere to time frames specified in Element A. The 6 months of data can extend beyond the look-back period; however, the report must be completed within the look-back period.

At a minimum, the timeliness report calculates rates of adherence to time frames for each category of request (urgent concurrent, urgent preservice, nonurgent preservice, post-service) for each factor. The organization generates reports to reflect differences if its processes or staff vary by product/product line.

Excluded from the timeliness report

The organization excludes the decisions and notification for nonemergency transportation approvals.

Timeliness of notifications sent for approvals is not required in this element.

Exceptions

None.

Examples **Timeliness reports**

Timeliness of notification of UM decisions—Commercial product line

	Urgent Concurrent	Urgent Preservice	Nonurgent Preservice	Postservice
Numerator[1]	350	560	875	689
Denominator[2]	400	575	880	689
Rate	87.5%	97.4%	99.4%	100%

[1]Numerator: The number of requests meeting the notification time frame.
[2]Denominator: The total number of all requests.

UM 6: Clinical Information

When making a determination of coverage based on medical necessity, the organization obtains relevant clinical information and consults with the treating practitioner.

Intent

The organization uses all information relevant to a member's care when it makes UM decisions.

Element A: Relevant Information

There is documentation that relevant clinical information is gathered consistently to support UM decision making.

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review~~	~~No scoring option~~	~~Medium (60-89%) on file review~~	~~No scoring option~~	~~Low (0-59%) on file review~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source

Records or files

Scope of review

NCQA reviews a random sample of up to 40 UM denial files resulting from medical necessity review (as defined in *UM 1: Program Structure,* Element A) for evidence of using relevant clinical information to support UM decision making.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

Although NCQA only reviews denial files during the file review process, this element applies to all UM determinations resulting from medical necessity review, whether they are approvals or denials.

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.

Relevant clinical information

Denial files contain clinical information appropriate to each case.

The relevance of clinical information is considered in terms of the criteria used by the organization to make its decision (i.e., the clinical information must be related to criteria stated in the denial notice as not met). Organizations must gather clinical information when determining medical necessity. If enough clinical information relevant to the criteria is not provided with the request, the organization must document in the denial file its attempts to gather the clinical information needed to make a decision.

Exceptions

None.

Related information

Refer to UM 1, Element A for the definition of “medical necessity review.”

Examples

Clinical information for determining coverage

Clinical information may include, but is not limited to:

- Office and hospital records.
- A history of the presenting problem.
- A clinical exam.
- Diagnostic testing results.
- Treatment plans and progress notes.
- Patient psychosocial history.
- Information on consultations with the treating practitioner.
- Evaluations from other health care practitioners and providers.
- A printed copy of criteria related to the request.
- Information regarding benefits for services or procedures.
- Information regarding the local delivery system.
- Patient characteristics and information.
- Information from family members.
- Diagnosis codes.

UM 7: Denial Notices

The organization clearly documents and communicates the reasons for each denial.

Intent

Members and practitioners receive information sufficient to understand and decide whether to appeal a decision to deny care or coverage.

Element A: Discussing a Denial With a Reviewer

The organization provides practitioners with the opportunity to discuss any UM denial decision with a physician, appropriate behavioral healthcare reviewer or pharmacist reviewer.

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review~~	~~No scoring option~~	~~Medium (60-89%) on file review~~	~~No scoring option~~	~~Low (0-59%) on file review~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review NCQA reviews a random sample of up to 40 UM denial files resulting from medical necessity review for evidence of opportunity for a practitioner to discuss a denial with a reviewer.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 12 months.

Explanation This element applies to all UM 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.

Opportunity to discuss denial decisions

The organization notifies the treating practitioner about the opportunity to discuss a medical necessity denial:

- In the denial notification, ***or***
- By telephone, including leaving a voicemail, if the organization documents the name of the individual at the organization who notified the treating practitioner

or left the voicemail, and the date and time of the notification or voicemail, ***or***

- In materials sent to the treating practitioner, informing the practitioner of the opportunity to discuss a specific denial with a reviewer.

The organization includes the following information in the denial file:

- The denial notification, if the treating practitioner was notified in the denial notification.
- The time and date of the notification and the name of the individual at the organization, if the treating practitioner was notified by telephone.
  - If the treating practitioner was notified by voicemail, the name of the individual who left the voicemail and the date and time.
- Evidence that the treating practitioner was notified that a physician or other reviewer is available to discuss the denial, if notified in materials sent to the treating practitioner.

NCQA does not require evidence of discussion with an attending or treating practitioner and does not consider the discussion to be an appeal.

For the Medicare product line, the organization may provide the treating practitioner with an opportunity to discuss a UM request with a physician or other appropriate reviewer prior to the decision to meet the intent of this element. The organization must provide documentation in the denial file.

Exceptions

None.

Examples None.

Element B: Written Notification of Denials

The organization's written notification of behavioral healthcare denials, that it provided to members and their treating practitioners, contains the following information:

1. **The specific reasons for the denial, in easily understandable language.**
2. **A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial 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 denial decision was based, upon request.**

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review for 3 factors~~	~~High (90-100%) on file review for 2 factors; medium (60-89%) on file review for 1 factor~~	~~At least medium (60-89%) on file review for 3 factors~~	~~Low (0-59%) on file review for 1-2 factors~~	~~Low (0-59%) on file review for 3 factors~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source

Records or files

Scope of review

NCQA reviews a random sample of up to 40 UM denial files resulting from medical necessity review for evidence that denial notices meet all three factors.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

THIS IS A MUST-PASS ELEMENT.

This element applies to all UM 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.

Factor 1: **Reason for denial**

The denial notification states the reason for 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 denied the request and have enough information to file an appeal.

An appropriately written notification includes a complete explanation of the grounds for the denial, 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."

Denial 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 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 denials resulting from medical necessity review of out-of-network requests, the reason for the denial must explicitly address the reason for the request. For example, if the request is based on insufficient accessibility for the clinical urgency of the situation, the denial must address that the requested service may be obtained within the organization's accessibility standards.

Factor 2: **Reference to UM criterion**

The denial 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 referenced 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). If the organization uses a trademarked criterion name, it does not need to cite the organization that holds the trademark (e.g., InterQual® Level of Care Criteria).

Because benefit documents are often large and complex, the organization must direct members to the information using the section title or page number.

For 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 denial notification informs the member, and the practitioner acting as 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 denial 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.

Exception

Factor 3 is NA for Medicare denials and Fully Integrated Dual Eligible (FIDE) denials.

Related information

Refer to *Related information* in UM 5, Element A for "Member Notification Exceptions" and "Notifying the Practitioner."

Denials due to insufficient clinical information.

- If the organization denies a request due to lack of clinical information, the denial notice must meet factors 1–3.
- If the organization does not have enough clinical information to reference a specific criterion, the denial notice must state this and specify the information needed.

Examples

***Factor 1:* Acceptable language documenting the reason for denial**

After reviewing our UM criteria for inpatient detoxification, which consider age, progress of treatment and outpatient programs available, [organization] has determined that you are no longer intoxicated or experiencing withdrawal symptoms and can be provided further treatment on an outpatient basis through the New Beginnings program; therefore, your request for continued inpatient treatment is denied.

Insufficient language documenting reason for denial

The treatment is determined to not be medically necessary.

***Factors 1, 2:* Denying an out-of-network exception request and referencing UM criteria**

A member's primary care practitioner requests out-of-network coverage for treatment of ADHD, explaining that only a specific pediatric psychiatrist can meet the member's needs. Medical records demonstrate initial screening by the primary care practitioner; no other medical or behavioral diagnoses are noted.
Our medical director has reviewed your child's primary care physician's request for coverage of treatment for attention deficit hyperactivity disorder (or "ADHD") with Dr. Jones, an out-of-network pediatric psychiatrist. As stated in your Certificate of Coverage under "Out of Network Coverage," your plan covers out-of-network practitioners only when your clinical needs cannot be met in-network. Your primary care physician did not provide evidence that your child has special needs related to the ADHD diagnosis or treatment. Several in-network pediatric psychiatrists are trained to diagnose and treat ADHD. Please work with your primary care physician to select an in-network practitioner.

***Factors 2, 3:* Acceptable language referencing decision-making criteria**

After reviewing and discussing your current symptoms with your practitioner, we believe that your condition has improved to the point where you no longer pose a danger to yourself or to others and can be managed appropriately in an intensive outpatient program. Because your symptoms no longer meet our Criteria for Inpatient Detoxification Monitoring, your request for further days in the hospital is denied.

You can obtain a copy of the criteria on which this decision was based by sending a request to us at the following address or contacting us by telephone.

Element C: Written Notification of Appeal Rights/Process

The organization's written behavioral healthcare denial notification to members and their treating practitioners contains the following information:

1. **A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal.**
2. **An explanation of the appeal process, including the member's right to representation and appeal time frames.**
3. **A description of the expedited appeal process for urgent preservice or urgent concurrent denials.**
4. **Notification that expedited external review can occur concurrently with the internal appeals process for urgent care.**

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review for 4 factors~~	~~High (90-100%) on file review for at least 3 factors and medium (60-89%) on file review for 1 factor~~	~~At least medium (60-89%) on file review for 4 factors~~	~~Low (0-59%) on file review for 1-2 factors~~	~~Low (0-59%) on file review for 3-4 factors~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review NCQA reviews a random sample of up to 40 UM denial files resulting from medical necessity review for evidence that denial notices meet all 4 factors.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 12 months.

Explanation

THIS IS A MUST-PASS ELEMENT.

This element applies to all UM 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.

Factor 1: **Description of appeal rights**

No additional explanation required.

Factor 2: **Right to representation and appeal time frames**

The denial notification:

- Includes a statement that members may be represented by anyone they choose, including an attorney.
- Provides contact information for a state office of health insurance consumer

assistance or ombudsperson, if applicable.
Note: *This is not required for members covered by the Federal Employee Health Benefits (FEHB) Program.*

- States the time frame for filing an appeal.
- States the organization's time frame for deciding the appeal.
- States the procedure for filing an appeal, including where to direct the appeal and information to include in the appeal.

The notification to the practitioner is not required to include the member's right to representation if the practitioner is not acting as an authorized representative.

Factor 3: **Expedited appeal process**

The denial notification describes the expedited appeal process for urgent preservice or urgent concurrent denials. If the same process applies to standard and expedited appeals, there must be a description included in the letter that makes it clear that the process applies to both. Factor 3 is met if the organization includes a description of the expedited appeal process in denial notices for every type of request.

The denial notification states:

- The time frame for filing an expedited appeal.
- The organization's time frame for deciding the expedited appeal.
- The procedure for filing an expedited appeal, including where to direct the appeal and information to include in the appeal.

Factor 4: **Concurrent expedited external review**

The denial notification states that for urgent care situations, expedited external review may occur at the same time as the internal appeal process.

The organization may discontinue the internal appeal for all member requests that were addressed by the external review if it is not required to continue the internal appeal process under state law. The organization continues the internal appeal process for components of the request that are not addressed in the external review.

The organization may include the information about concurrent expedited external review to member notifications only.

Exceptions

Factor 4 is NA for:

- Members covered by Medicare, Medicaid or the FEHB Program and for members in self-funded accounts.
- Nonurgent preservice and postservice denial decisions.

Related information

Refer to *Related information* in UM 5, Element A for "Member Notification Exceptions" and "Notifying the Practitioner."

Medicare denials and Fully Integrated Dual Eligible (FIDE) denials. CMS requires organizations to issue an Integrated Denial Notice (IDN) for non-inpatient medical service denials for Medicare and FIDE members. The IDN meets factors 1–3 for these members.

Examples None.

UM 8: Policies for Appeals

The organization has written policies and procedures for thorough, appropriate and timely resolution of member appeals.

Intent

There is an established and impartial process for resolving member disputes and responding to member requests to reconsider a decision they find unacceptable regarding their care and service.

Element A: Internal Appeals

The organization's written policies and procedures for registering and responding to written internal appeals include the following:

1. **For commercial and Exchange, allowing at least 180 calendar days after notification of the denial for the member to file an appeal.**
2. **For Medicare and Medicaid, allowing at least 60 calendar days after notification of the denial for the member to file an appeal.**
3. **Documenting the substance of the appeal and any actions taken.**
4. **Full investigation of the substance of the appeal, including any aspects of clinical care involved.**
5. **The opportunity for the member to submit written comments, documents or other information relating to the appeal.**
6. **Appointment of a new person to review the appeal who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination.**
7. **Appointment of at least one person to review the appeal who is a practitioner in the same or a similar specialty.**
8. **The decision for a preservice appeal and notification to the member within 30 calendar days of receipt of the request.**
9. **The commercial, Exchange and Medicare decision for a postservice appeal and notification to the member within 60 calendar days of receipt of the request.**
10. **For Medicaid, the decision for a postservice appeal and notification to the member within 30 calendar days of receipt of the request.**
11. **The decision for an expedited appeal and notification to the member within 72 hours of receipt of the request.**
12. **Notification to the member about further appeal rights.**
13. **Referencing the benefit provision, guideline, protocol or other similar criterion on which the appeal decision is based.**
14. **Giving members reasonable access to and copies of all documents relevant to the appeal, free of charge, upon request.**
15. **Including a list of titles and qualifications, including specialties, of individuals participating in the appeal review.**
16. **Allowing an authorized representative to act on behalf of the member.**

17. Providing notices of the appeals process to members in a culturally and linguistically appropriate manner.

18. Continued coverage pending the outcome of an appeal.

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

~~Scoring~~

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 18 factors~~	~~The organization meets 14-17 factors~~	~~The organization meets 9-13 factors~~	~~The organization meets 4-8 factors~~	~~The organization meets 0-3 factors~~

Met	Partially Met	Not Met
The organization meets 14-18 factors	The organization meets 4-13 factors	The organization meets 0-3 factors

Data source Documented process

Scope of review NCQA reviews the organization's policies and procedures.

Look-back period

For Initial Surveys: 6 months.

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.

This element applies to decisions of appeals related to coverage or rescission of coverage, whether or not the denial resulted from medical necessity review (e.g., medical, behavioral health, pharmacy or personal care services).

A member may appeal any adverse medical necessity or benefit decision.

With a member's permission, the organization may refer an appeal directly to an IRO without conducting an internal review.

Definition of appeal requests

Preservice appeal: An appeal of an adverse decision for coverage of care or services in advance of the member obtaining care or services.

Postservice appeal: A request to change an adverse determination for care or services that have been received by the member.

Expedited appeal: An appeal on an adverse decision for coverage for urgent care.

Factor 1, 2: **Appeal filing time frames**

Appeal policies and procedures include the following time frames for members (or their authorized representatives) to file an appeal, as applicable:

- *For commercial and Exchange product lines:* 180 calendar days or more.
- *For the Medicare and Medicaid product line:* 60 calendar days.

Factor 3: **Documenting the substance of an appeal and actions taken**

Appeal policies and procedures specify that documentation of the substance of the appeal includes, but is not limited to:

- The member's reason for appealing the previous decision.
- Additional clinical or other information provided with the appeal request.

Appeal policies and procedures specify that documentation of actions taken includes, but is not limited to:

- Previous denial or appeal history.
- Follow-up activities associated with the denial and conducted before the current appeal, if applicable.

The organization determines the extent of documentation in the appeal file.

Factor 4: **Investigating the substance of an appeal**

Appeal policies and procedures specify that the organization fully investigates the content of the appeal and documents its findings. The organization's appeal review does not give deference to the denial decision.

Factor 5: **Right to submit comments and other information**

Appeal policies and procedures specify that members have the opportunity to submit information relevant to the appeal. The organization documents when members fail to submit relevant information by the specified deadline.

Factor 6: **Person or people deciding the appeal**

Appeal policies and procedures specify who in the organization decides appeals.

The organization may designate any individual or group (e.g., a panel) in its policies and procedures to overturn appeals and to uphold appeals that do not require medical necessity review.

For appeals that require medical necessity review, the final decision to uphold an appeal must be made by an appropriate practitioner or a group (e.g., a panel) that includes an appropriate practitioner who was not involved in the initial denial decision and is not subordinate to the practitioner who made the initial denial decision.

NCQA considers the following practitioner types to be appropriate for review of the specified UM denial decisions:

- *Physicians, all types:* Medical, behavioral healthcare, pharmaceutical, dental, chiropractic and vision denials.
- *Nurse practitioners*:* Medical, behavioral healthcare, pharmaceutical, dental, chiropractic and vision denials.
- *Doctoral-level clinical psychologists or certified addiction-medicine specialists:* Behavioral healthcare denials.
- *Pharmacists:* Pharmaceutical denials.
- *Dentists:* Dental denials.
- *Chiropractors:* Chiropractic denials.
- *Physical therapists:* Physical therapy denials.
- *Doctoral-level board-certified behavioral analysts:* Applied behavioral analysis denials.

* *In states where the organization has determined that practice acts or regulations allow nurse practitioners to practice independently, nurse practitioners may review requests that are within the scope of their license.*

Factor 7: **Same-or-similar specialist review**

Appeal policies and procedures require same-or-similar specialist review as part of the process to uphold the initial decision in an appeal that requires medical necessity review.

The purpose of same-or-similar specialist review of appeals is to apply specific clinical knowledge and experience when determining if an appeal meets criteria for medical necessity and clinical appropriateness.

The same-or-similar specialist may be the same individual designated to make the appeal decision or may be a separate reviewer who provides a recommendation to the individual making the decision. The same-or-similar specialist may be any of the practitioner types specified in factor 6, with the exception of pharmacists, because pharmacists generally treat patients only in limited situations and therefore are not considered same-or-similar specialists for the purposes of deciding appeals.

To be considered a same-or-similar specialist, the reviewing specialist's training and experience must meet the following criteria:

- Includes treating the condition.
- Includes treating complications that may result from the service or procedure.
- Is sufficient for the specialist to determine if the service or procedure is medically necessary or clinically appropriate.

"Training and experience" refers to the practitioner's clinical training and experience.

When reviewing appeal files, NCQA reviews whether the specialist's training and experience aligns with the condition, service or procedure in question, as opposed to requiring an exact match to the referring or treating practitioner type or specialty.

The intent is that the specialist reviewing the appeal would have encountered a patient with this condition who is considering or has received the service or procedure in a clinical setting. Because of this, more complex services and procedures require review by practitioners with more specialized training and experience. For example, while a decision to uphold a denial of hospital admission for arrhythmia might be reviewed by any number of practitioners, including, but not limited to, a cardiologist, cardiothoracic surgeon, internist, family practitioner, geriatrician or emergency medicine physician, a decision to uphold a denial of surgery to repair an atrial septal defect in a newborn would require review by a cardiothoracic surgeon with pediatric experience.

NCQA accepts board certification in a specialty as a proxy for clinical training and experience. A specialist who maintains board certification in a general and specialty area (e.g., internal medicine and pulmonology) is considered to have training and experience in both areas. NCQA does not require that the same-or-similar specialist reviewer be actively practicing.

Experience with the condition, service or procedure that is limited to UM decision making in cases similar to the appeal in question is not considered sufficient experience, nor do UM decision-making criteria supersede the requirement for same-or-similar specialist review.

If the organization's clinical criteria limits who can perform a service or procedure, or who can prescribe a pharmaceutical to specific practitioner types or specialties,

then only those practitioner types or specialties may be considered same-or-similar specialist reviewers.

Factors 8–11: **Appeal decisions**

Appeal policies and procedures specify that appeal decisions and notification are timely. 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 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 the upheld appeal 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 expedited appeals (factor 11), appeal policies and procedures specify that the organization grants an expedited review for all requests concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from a facility.

Factor 12: **Notification of further appeal rights**

Appeal policies and procedures include a description of the next level of appeal, either within the organization or to an external organization, as applicable, and relevant written procedures.

Factor 13: **Reference to and excerpt from criteria**

Appeal policies and procedures specify that the appeal notification references the specific criterion used to make the appeal decision.

Appeal policies and procedures specify that the organization informs the member or the member's authorized representative, that the criterion used to make the decision is available upon request. The criterion availability component of factor 13 is met if the policies and procedures specify that the criterion, or an excerpt of the criterion, is included in the decision notice or as an attachment.

Factor 14: **Access to and copies of documents**

No additional explanation required.

Factor 15: **Titles and qualifications**

Appeal policies and procedures require the appeal notice to identify 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 16: **Authorized representative**

No additional explanation required.

Factor 17: **Culturally and linguistically appropriate notification**

Appeal policies and procedures specify that appeal notices are based on members' cultural and linguistic needs.

Factor 18: **Continued coverage pending outcome of appeal**

Note: This factor applies to appeals of denials or reduction or termination of coverage for an ongoing course of treatment for which coverage was previously approved. It does not apply to requests for extensions.

Appeal policies and procedures allow continued coverage, pending the outcome of an internal appeal of a concurrent care decision until:

- The end of the approved treatment period, ***or***
- Determination of the appeal, subject to regulatory and contractual obligations.

If the outcome of the appeal is in the organization's favor, NCQA standards do not prohibit the organization from seeking reimbursement from the member for payments made.

Medicare appeals for factors 8, 9,11–13. The organization's policies and procedures describe its process for sending an upheld denial to MAXIMUS.

Medicare Part D appeals for factors 8, 9, 11–13. The organization describes its process for notifying members that an upheld denial should be sent to MAXIMUS.

Exceptions

Factor 1 is NA for Medicare and Medicaid product lines.

Factor 2 is NA for commercial and Exchange product lines.

Factor 9 is NA for Medicaid product lines.

Factor 10 is NA for commercial, Medicare and Exchange product lines.

Factors 14 and 15 are NA for Medicare Part D appeals.

For factor 14, the "free of charge" component is NA for Medicare appeals.

Factor 18 is NA if the organization does not provide or administer coverage for members.

Related information

Discussion with the practitioner. NCQA does not consider a request by a treating practitioner to discuss the decision with an appropriate practitioner reviewer in *UM 7: Denial Notices,* Element A, to be an initiation the appeal process.

Extending the time frame to obtain additional information. Although there are allowable extensions for initial UM decisions, the organization may only extend the appeal time frame to obtain additional information when:

- The member agrees to extend the appeal time frame, ***or***
- Federal program regulations allow the organization to request additional information from the member.

Allowable extensions for the Medicare and Medicaid product line only. For Medicare and Medicaid, the organization may allow a 14-day extension if the member requests the extension or the organization demonstrates that more information is needed and the delay is in the member's interest.

Verbal notification. Verbal notification does not replace electronic or written notification of expedited appeal decisions, but when provided, the organization may extend the time frame for commercial, Medicare and Exchange decisions as described below.

- Verbal notification requires communication with a 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 72 hours.

For commercial, Medicare and Exchange appeals, if the organization provides verbal notification for an expedited appeal, it has an additional 3 calendar days following verbal notification to provide electronic or written notification.

For Medicaid appeals, verbal notification is appropriate for nonurgent preservice, postservice and expedited appeals. Verbal notification of a decision does not extend the electronic or written notification time frame. Organizations may verbally inform members if there is a delay and must resolve appeals as expeditiously as the member's health requires.

Expedited appeals. The organization may inform the hospital Utilization Review (UR) department staff of its decision, with the understanding that staff will inform the attending/treating practitioner. Notifications may be addressed to the hospital UR department, but must be to the attention of the attending or treating practitioner.

FEHB member appeals. For FEHB Program member appeals for which the organization requested additional information, NCQA gives the organization credit for factor 8 if its policies state that it makes appeal decisions within 30 calendar days after the date when the information was received.

Note: This may extend the normal 30-calendar-day preservice time frame.

Other levels of internal appeal. An organization may have two levels of internal appeal and may also have voluntary levels of appeal beyond the internal appeal process. The organization informs members of the process. Policies and procedures specify the time frames allocated for each level of internal appeal; however, the total of both time frames must be the same or less than the time frame specified for the type of appeal under review. For example, for a preservice appeal where NCQA allows 30 calendar days, the organization may allocate 10 calendar days to complete first-level appeals and 20 calendar days to complete second-level appeals.

The 180-calendar-day allowance for filing an appeal applies to first-level appeals.

NCQA standards do not specify a minimum time frame for members to file a

second-level appeal following the decision on a first-level appeal.

Policies and procedures specify the level of review that includes same-or-similar-specialist review.

The organization suspends the statute of limitations or other legal or equitable basis for denial of the claim based on timeliness while a voluntary appeal is pending.

Use of practitioner web portals. The organization may provide electronic upheld appeal decision 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 8 and UM 9. 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 upheld appeal decision 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 8 and UM 9. 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.

Examples None.

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 A: Preservice and Postservice Appeals

An NCQA review of the organization's appeal files indicates that there is:

1. **Documentation of the substance of appeals.**
2. **Investigation of appeals.**
3. **Appropriate response to the substance of the appeal.**

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review for 3 factors~~	~~High (90-100%) on file review for 2 factors and medium (60-89%) on file review for 1 factor~~	~~At least medium (60-89%) on file review for 3 factors~~	~~Low (0-59%) on file review for 1 factor~~	~~Low (0-59%) on file review for 2-3 factors~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review NCQA reviews a random sample of up to 40 upheld appeal files for evidence the appeal file contains all three 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 Initial Surveys:* 6 months.

For Renewal Surveys: 12 months.

Explanation 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: **Documentation of the substance of the appeal**

The organization's documentation for the appeal includes:

- The member's reason for appealing the previous decision.
- Actions taken including, but not limited to:
  - Previous denial or appeal history.
  - Follow-up activities associated with the denial and conducted before the current appeal, if applicable.

Factor 2: **Documentation of the investigation of appeals**

The organization investigates the content of the appeal, including all aspects of clinical care involved, and documents its findings. The investigation does not defer to the denial decision.

Factor 3: **Appropriate response to the substance of appeals**

The organization's response is commensurate with the seriousness and urgency of the appeal. It directly responds to the reasons given by the member when appealing and addresses new information provided by the member or practitioner as part of the appeal.

Exceptions

None.

Related information

Personal care services. Benefit appeal files include appeals for personal care services, such as cooking, grooming, transportation, cleaning and assistance with other activities of daily living.

Examples None.

Element B: Timeliness of the Appeal Process

The organization adheres to the following time frames for notification of preservice, postservice and expedited appeal decisions:

1. **For preservice appeals, the organization gives electronic or written notification within 30 calendar days of receipt of the request.**
2. **For commercial, Exchange, and Medicare postservice appeals, the organization gives electronic or written notification within 60 calendar days of receipt of the request.**
3. **For Medicaid postservice appeals, the organization gives electronic or written notification within 30 calendar days of the request.**
4. **For expedited appeals, the organization gives electronic or written notification within 72 hours of receipt of the request**

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review~~	~~No scoring option~~	~~Medium (60-89%) on file review~~	~~No scoring option~~	~~Low (0-59%) on file review~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source

Records or files

Scope of review

NCQA reviews a random sample of up to 40 upheld appeal files for evidence of timeliness of resolution, including decision making and notification. 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 Initial 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.

Factors 1–4: **Timeliness of appeal process**

NCQA considers 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 or member's authorized representative, as applicable.

The organization documents the date when it receives the request, and the date it resolves the appeal, in the appeal file. The request is received when it arrives at the organization, even if it is not received by the appeals department.

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.

Exceptions

Factor 2 is NA for the Medicaid product line.

Factor 3 is NA for commercial, Medicare, and Exchange product lines.

Related information

Extending the decision time frame. The organization may extend the appeal time frame to obtain additional information if:

- The member agrees to extend the appeal time frame, ***or***
- Federal program regulations allow the organization to request additional information from the member.

The organization may deny the appeal and notify the member if it does not receive the information within the time frames.

The organization documents the extension in the appeal file.

Allowable extensions for the Medicare and Medicaid product line only. For Medicare and Medicaid, the organization may allow a 14-day extension if the member requests the extension or the organization demonstrates that more information is needed and the delay is in the member's interest.

Verbal notification. Verbal notification does not replace electronic or written notification of expedited appeal decisions, but when provided, the organization may extend the time frame 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 72 hours.

For commercial, Medicare and Exchange appeals, if the organization provides verbal notification for an expedited appeal, it has an additional 3 calendar days following verbal notification to provide electronic or written notification.

For Medicare Part C appeals, the date when the upheld denial is sent to MAXIMUS is the date of notification.

For Medicaid appeals, verbal notification is appropriate for nonurgent preservice, postservice and expedited appeals. Verbal notification of a decision does not extend the electronic or written notification time frame. Organizations may verbally inform members if there is a delay and must resolve appeals as expeditiously as the member's health requires.

Expedited appeals. The organization may inform the hospital Utilization Review (UR) department staff of its decision, with the understanding that staff will inform the attending/treating practitioner. Notifications may be addressed to the hospital UR department, but must be to the attention of the attending or treating practitioner.

FEHB member appeals. For FEHB Program member appeals for which the organization requested additional information, preservice and postservice appeal files meet factors 1 and 2 if the decision was made within 30 calendar days after the date when the information was received.

Note: This may extend the preservice and postservice appeal time frames.

Other levels of internal appeal. An organization may have two levels of internal appeal, and may also have voluntary levels of appeal beyond the internal appeal process. The organization informs members of the process. Policies and procedures specify the time frames allocated for each level of internal appeal; however, the total of both time frames must equal or be less than the time frame specified for the type of appeal under review. For example, for a preservice appeal where NCQA allows 30 calendar days, the organization may allocate 10 calendar days to complete first-level appeals and 20 calendar days to complete second-level appeals.

The 180-calendar-day allowance for filing an appeal applies to first-level appeals.

NCQA standards do not specify a minimum time frame for members to file a second-level appeal following the decision on a first-level appeal.

Policies and procedures specify the level of review that includes same-or-similar-specialist review.

The organization suspends the statute of limitations or other legal or equitable basis for denial of the claim based on timeliness while a voluntary appeal is pending.

Use of practitioner web portals. The organization may provide electronic upheld appeal decision 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 requirement in UM 8 and UM 9. 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 upheld appeal decision 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 8 and UM 9. 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.

Examples None.

Element C: Appeal Reviewers

The organization provides nonsubordinate reviewers who were not involved in the previous determination and same-or-similar-specialist review, as appropriate.

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review~~	~~No scoring option~~	~~Medium (60-89%) on file review~~	~~No scoring option~~	~~Low (0-59%) on file review~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review NCQA reviews a random sample of up to 40 upheld appeal files for evidence of involvement of nonsubordinate and same-or-similar specialist reviewers. 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 Initial Surveys:* 6 months.

For Renewal Surveys: 12 months.

Explanation 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.

Person or people deciding the appeal

The organization may designate any individual or group (e.g., a panel) to overturn appeals and to uphold appeals that do not require medical necessity review.

However, for appeals that require medical necessity review, the final decision to

uphold an appeal must be made by an appropriate practitioner or a group (e.g., a panel) that includes an appropriate practitioner who was not involved in the initial denial decision and is not subordinate to the practitioner who made the initial denial decision.

NCQA considers the following practitioner types to be appropriate for review of the specified UM denial decisions:

- *Physicians, all types:* Medical, behavioral healthcare, pharmaceutical, dental, chiropractic and vision denials.
- *Nurse practitioners*:* Medical, behavioral healthcare, pharmaceutical, dental, chiropractic and vision denials.
- *Doctoral-level clinical psychologists or certified addiction-medicine specialists:* Behavioral healthcare denials.
- *Pharmacists:* Pharmaceutical denials.
- *Dentists:* Dental denials.
- *Chiropractors:* Chiropractic denials.
- *Physical therapists:* Physical therapy denials.
- *Doctoral-level board-certified behavioral analysts:* Applied behavioral analysis denials.

* *In states where the organization has determined that practice acts or regulations allow nurse practitioners to practice independently, nurse practitioners may review requests that are within the scope of their license.*

Same-or-similar specialist review

Same-or-similar specialist review is a required part of the process to uphold the initial decision in an appeal that requires medical necessity review.

The purpose of same-or-similar specialist review of appeals is to apply specific clinical knowledge and experience when determining if an appeal meets criteria for medical necessity and clinical appropriateness.

The same-or-similar specialist may be the same individual designated to make the appeal decision or may be a separate reviewer who provides a recommendation to the individual making the decision. The same-or-similar specialist may be any of the practitioner types specified above, with the exception of pharmacists, because pharmacists generally treat patients only in limited situations and therefore are not considered same-or-similar specialists for the purposes of deciding appeals.

To be considered a same-or-similar specialist, the reviewing specialist's training and experience must meet the following criteria:

- Includes treating the condition.
- Includes treating complications that may result from the service or procedure.
- Is sufficient for the specialist to determine if the service or procedure is medically necessary or clinically appropriate.

"Training and experience" refers to the practitioner's clinical training and experience.

When reviewing appeal files, NCQA reviews whether the specialist's training and experience aligns with the condition, service or procedure in question, as opposed to requiring an exact match to the referring or treating practitioner type or specialty.

The intent is that the specialist reviewing the appeal would have encountered a patient with this condition who is considering or has received the service or procedure in a clinical setting. Because of this, more complex services and

procedures require review by practitioners with more specialized training and experience. For example, while a decision to uphold a denial of hospital admission for arrhythmia might be reviewed by any number of practitioners, including, but not limited to, a cardiologist, cardiothoracic surgeon, internist, family practitioner, geriatrician or emergency medicine physician, a decision to uphold a denial of surgery to repair an atrial septal defect in a newborn would require review by a cardiothoracic surgeon with pediatric experience.

NCQA accepts board certification in a specialty as a proxy for clinical training and experience. A specialist who maintains board certification in a general and specialty area (e.g., internal medicine and pulmonology) is considered to have training and experience in both areas. NCQA does not require that the same-or-similar specialist reviewer be actively practicing.

Experience with the condition, service or procedure that is limited to UM decision making in cases similar to the appeal in question is not considered sufficient experience, nor do UM decision-making criteria supersede the requirement for same-or-similar specialist review.

If the organization's clinical criteria limits who can perform a service or procedure, or who can prescribe a pharmaceutical to specific practitioner types or specialties, then only those practitioner types or specialties may be considered same-or-similar specialist reviewers.

Exceptions

None.

Related information

Same-or-similar specialist review with two levels of appeal. If a second-level appeal file is chosen for review, NCQA reviews the file for all requirements, including for same-or-similar specialist review, even if same-or-similar specialist review occurs at the first level of appeal.

If a first-level appeal file is chosen, and the same-or-similar specialist review occurs at the second level:

- NCQA scores the same-or-similar specialist review NA if the second-level appeal has not taken place.
- NCQA scores all requirements, including same-or-similar specialist, if the second-level appeal has taken place.

Nonsubordinate reviewers with multiple levels of appeal. Nonsubordinate reviewers are required at each level of the appeal process for appeals that require medical necessity review.

Automated systems. If the initial denial decision was made by an automated system (e.g., claims system), any reviewer is considered new and nonsubordinate.

Contracting with a licensed consultant. NCQA does not consider it delegation if the organization contracts with licensed consultants who make recommendations and provide same-or-similar specialty review. If the consultant makes the appeal decision, NCQA considers this to be delegation.

Examples None.

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. **The 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 relevant to the appeal, 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.**

Summary of Changes

- Added factor 7.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review for 6 factors~~	~~High (90-100%) on file review for 4-5 factors and medium (60-89%) on file review for the remaining 1-2 factors~~	~~At least medium (60-89%) on file review for 6 factors~~	~~Low (0-59%) on file review for 1-3 factors~~	~~Low (0-59%) on file review for 4 or more factors~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review 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 Initial 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 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 is a test that 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 referenced 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).

If the organization uses a trademarked criterion name, it does not need to cite the organization that holds the trademark (e.g., InterQual® Level of Care Criteria).

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. The statement that members are not required to bear costs of the IRO, including filing fees, does not apply to appeals by members in self-funded accounts or to members covered by Medicare, Medicaid or the FEHB Program.

If the organization instructs the members 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.

~~**Element E: Final Internal and External Appeal Files**~~

~~**In an NCQA review of denials overturned by the IRO or of the organization's final internal denials, the files included the following:**~~

1. ~~**Member notification of independent appeal rights.**~~
2. ~~**Member notification about obtaining more information regarding independent appeal rights.**~~
3. ~~**A statement that members are not required to bear costs of the IRO, including filing fees.**~~

~~**Summary of Changes**~~

~~**Clarifications**~~

- ~~Revised the first bullet in the exceptions to clarify that the element is NA if the organization had no denials overturned by the IRO and no final internal denials during the look-back period.~~

~~**Scoring**~~

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 3 factors~~	~~The organization meets 2 factors~~	~~The organization meets 1 factor~~	~~No scoring option~~	~~The organization meets 0 factors~~

Data source Records or files

Scope of review NCQA reviews five of the most recently overturned appeals by the IRO, or reviews five final internal denials if no appeals were overturned by the IRO. If there are fewer than five files, NCQA reviews all files.

NCQA scores this element for each file. The score for the element is the average of the scores for all files.

This file review is independent of the appeal file review performed for UM 9, Elements A–D.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 24 months.

Explanation 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: **Notification of independent appeal rights**

The denial letter includes a statement about eligibility for external review.

Factor 2: **Information about independent appeal rights**

No additional explanation required.

Factor 3: **Cost of the 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.

Exceptions

This element is NA:

- If the organization had no denials overturned by the IRO and no final internal denials during the look-back period.
- For appeals by members covered by Medicare, Medicaid or the FEHB Program.
- For appeals by members in self-funded accounts.
- If the employer mandates that its employees go through its external appeal process.

Examples None.

Element F: Appeals Overturned by the IRO

In an NCQA review of the organization's files of appeals overturned by the IRO, there is evidence that the organization implemented the IRO's decision in all cases reviewed.

Summary of Changes

Clarifications

- Revised the first bullet under the exceptions to clarify that the element is NA for organizations that had no appeals overturned by the IRO and no final internal denials.

Scoring

100%	80%	50%	20%	0%
The organization meets the requirement	No scoring option	No scoring option	No scoring option	The organization does not meet the requirement

Data source Records or files

Scope of review NCQA reviews five of the most recently overturned appeals by the IRO, or reviews five final internal denials, if no appeals were overturned by the IRO. If there are fewer than five files, NCQA reviews all files.

NCQA scores this element for each file. The score for the element is the average of the scores for all files.

This file review is independent of the appeal file review performed for UM 9, Elements A–D.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 24 months.

Explanation 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.

Exceptions

This element is NA:

- If the organization had no appeals overturned by the IRO and no final internal denials during the look-back period.
- For appeals by members covered by Medicare, Medicaid or the FEHB Program.
- For appeals by members in self-funded accounts.

Examples None.

UM 10: Functionality of Claims Processing

The organization provides members with timely and accurate information about their claims.

Intent

The organization allows members to access and track claims through the claims process

on its website and by telephone.

Element A: Functionality: Website

Members can track the status of their claims in the claims process and obtain the following information on the organization's website in one attempt or contact:

1. **The stage in the process.**
2. **The amount approved.**
3. **The amount paid.**
4. **The member's cost.**
5. **The date paid.**

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 5 factors~~	~~The organization meets 4 factors~~	~~The organization meets 2-3 factors~~	~~No scoring option~~	~~The organization meets 0-1 factors~~

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 NCQA reviews the organization's website content and functionality against the requirements of this element. Both must be in place throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen shots of web functionality, supplemented with documents specifying the required features and functions of the site. If screen shots provided include detailed explanations of how the site works, there is no need to provide supplemental documents.

Look-back period *For Initial Surveys:* 6 months.

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.

The organization provides evidence that it can perform all activities required by this element, even if no clients purchase the services.
The organization meets the requirement of "one attempt or contact" if:

- Members can access all required website function in one session without the need to sign in again or contact the organization.
- The website contains links to other organizations that provide the information

stated in the factors.

***Factor 1:* The stage in the process**

Members can access and track claims in all stages of the claim process on the organization's website. NCQA does not review individual claims, and expects that data are present only if applicable to the specific stage in the claim process.

Factors 2–4

No additional explanation required.

***Factor 5:* Date paid**

"Date paid" is the date when the claim is processed for payment or the date when the check is cut.

Exceptions

This element is NA:

- If the organization's health plan clients process all claims.
- If 90% or more of the organization's claims payments (measured in dollars, not in the number of claims processed or encounters) are under capitation and members have no financial responsibility beyond a flat copay.
- For services that are carved out for a specific employer group, and the organization does not process claims for carved-out services.
- If members have no 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 for the formulary) for services beyond a flat copay that is always the same fixed dollar amount and cannot be balance-billed by a practitioner, provider or other party.
  - The flat copayment amount is specified on the organization's website. It may be different 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).

The organization provides documentation to support a score of "NA."

Related information

Use of vendors for claims processing services. If the organization contracts with a vendor to provide web-based claims processing services, it provides access to the vendor's claims processing system. NCQA does not consider the relationship to be delegation and delegation oversight is not required under UM 12. NCQA evaluates the vendor's system against the requirements. Refer to *Vendors* in *Appendix 3: Delegation and Automatic Credit Guidelines*.

Examples None.

Element B: Functionality: Telephone Requests

Members can track the status of their claims in the claims process and obtain the following information over the telephone in one attempt or contact:

1. **The stage in the process.**
2. **The amount approved.**
3. **The amount paid.**
4. **The member's cost.**

5. The date paid.

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 5 factors~~	~~The organization meets 4 factors~~	~~The organization meets 3 factors~~	~~The organization meets 2 factors~~	~~The organization meets 0-1 factors~~

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 NCQA reviews evidence of how the organization's telephone system meets each factor throughout the look-back period.

For live-person systems, NCQA reviews policies and procedures, scripts and other resources used by Member Services staff.

For automated systems, NCQA reviews evidence of functional capability or scripts, supplemented with documents specifying the required features and stating that the telephone system functions as required.

Look-back period *For Initial Surveys:* 6 months.

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.

The organization provides evidence that it can perform the activities required by this element, even if the required functions have not been purchased by a client.

The organization meets the requirement for all five factors, even if a specific factor does not apply to a specific claim. A notation may be made in the organization's system regarding claim status (i.e., pending or denied).

One attempt or contact

The organization meets the requirement of "one attempt or contact" if members can complete all the required functions over the telephone without needing to make more than one call. The organization may have an automated system that answers and triages an initial call, but once the member reaches a live person, providing the member with another number to call, transferring the member to voicemail or into a phone queue does not meet the requirement.
The organization may use:

- A live-person or automated telephone system to provide the information, ***or***
- A live-person telephone transfer to another person or organization.

After-hours calls

Calls received after normal business hours are returned within one business day.

Calls received after midnight are responded to the same business day. If the organization does not have a voicemail system, it has another method to track calls that are received after normal business hours, and returns those calls on the next business day.

Factor 1: **Stage in the process**

Members can access and track claims over the telephone for all stages of the payment process. NCQA does not review individual claims, and expects that data are present only if applicable to the specific stage in the claim process.

Factors 2–4

No additional explanation required.

Factor 5: **Date paid**

"Date paid" is the date when the claim is processed for payment or the date when the check is cut.

Exception

This element is NA if the organization's health plan clients process all claims.

Examples

Evidence of the claims process by telephone

- Tracking logs that contain responses to applicable factors.
- Decision-tree script provided to Member Services staff.

UM 11: UM Information Integrity

The organization has UM information integrity policies and procedures, audits UM information for inappropriate documentation and updates and implements corrective actions that address identified information integrity issues.

Intent

The organization demonstrates its commitment to protecting the integrity of UM information used in in the processing of UM denials and UM appeals.

Element A: Protecting the Integrity of UM Denial Information

The organization has UM denial information integrity policies and procedures that specify:

1. **The scope of UM information.**
2. **The staff responsible for completing UM activities.**
3. **The process for documenting updates to UM information.**
4. **Inappropriate documentation and updates.**
5. **The organization audits UM staff and the process for documenting and reporting identified information integrity issues.**

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 4-5 factors~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization meets 0-3 factors~~

Met	Partially Met	Not Met
The organization meets 4-5 factors	No scoring option	The organization meets 0-3 factors

Data source Documented process

Scope of review NCQA reviews the organization's policies and procedures for protecting the integrity of UM information.

Look-back period *For Initial and Renewal Surveys:* Prior to the survey date.

Explanation

THIS IS A MUST-PASS ELEMENT.

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

This element applies to UM information (both paper and electronic) used in the UM denial process (UM 4–UM 7).

UM denial information integrity refers to maintaining and safeguarding information

used in UM denial decision process against inappropriate documentation and updates.

The organization's UM information integrity policies and procedures specifically address the integrity of information used in UM denial process.

Factor 1: **Scope of UM information**

The organization's information integrity policies and procedures specify protection of each of the following types of information:

- UM requests from members or their authorized representatives.
- UM request receipt date.
- Appropriate practitioner review.
- Use of board-certified consultants.
- Clinical information collected and reviewed.
- UM decisions.
- UM decision notification date.
- UM denial notices.

The organization defines the dates of receipt and written notification for UM denial determinations resulting from medical necessity review, consistent with requirements in UM 5.

Factor 2: **Staff responsible for performing UM activities**

The organization's policies and procedures specify the titles of staff who are:

- Responsible for documenting completion of UM activities.
- Authorized to modify (edit, update, delete) UM information.
  - Policies and procedures state if no staff are authorized to modify dates under any circumstances.
- Responsible for oversight of UM information integrity functions, including auditing.

Factor 3: **Process for documenting updates to UM information**

The organization's policies and procedures:

- Specify when updates to existing UM information is appropriate (e.g., the member sends an updated request or corrects a typographical error).
- Describe the organization's process for documenting the following when updates are made to UM information:
  - When (e.g., date and time) the information was updated.
  - What information was updated.
  - Why the information was updated.
  - Staff who updated the information.

Factor 4: **Inappropriate documentation and updates**

The organization's policies and procedures specify that the following documentation and updates to UM information are inappropriate:

- Falsifying UM dates (e.g., receipt date, UM decision date, notification date).
- Creating documents without performing the required activities.
- Fraudulently altering existing documents (e.g., clinical information, board certified consultant review, denial notices).
- Attributing review to someone who did not perform the activity (e.g.,

appropriate practitioner review).
- Updates to information by unauthorized individuals.

Factor 5: **Auditing, documenting and reporting information integrity issues**

The organization's policies and procedures:

- Specify that the organization audits UM staff documentation and updates.
  - The organization does not have to include the audit methodology, but must indicate that an annual audit is performed.
- Describe the process for documenting and reporting inappropriate documentation and updates to:
  - The organization's designated individual(s) when identified.
  - NCQA, when the organization identifies fraud and misconduct.
    - Refer to *Notifying NCQA of Reportable Events* in Section 5 of the Policies and Procedures for details.
  - Specify consequences for inappropriate documentation and updates.

Exceptions

None.

Examples None.

Element B: Protecting the Integrity of UM Appeal Information

The organization has UM appeal information integrity policies and procedures for:

1. **The scope of UM information.**
2. **The staff responsible for performing UM activities.**
3. **The process for documenting updates to UM information.**
4. **Inappropriate documentation and updates.**
5. **The organization audits UM staff and the process for documenting and reporting information integrity issues, when identified.**

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 4-5 factors~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization meets 0-3 factors~~

Met	Partially Met	Not Met
The organization meets 4-5 factors	No scoring option	The organization meets 0-3 factors

Data source Documented process

Scope of review

NCQA reviews the organization's policies and procedures for protecting the integrity of UM appeal information.

Look-back period

For Initial and Renewal Surveys: Prior to the survey date.

Explanation

THIS IS A MUST-PASS ELEMENT.

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

This element applies to UM information (both paper and electronic) used in the appeal process (UM 8–UM 9).

UM appeal information integrity refers to maintaining and safeguarding information used in the UM appeal process against inappropriate documentation and updates.

The organization's UM information integrity policies and procedures may be separate or may be incorporated in other organizational policies and procedures.

Factor 1: **Scope of UM information**

The organization's UM appeal information integrity policies and procedures specify protection of each of the following types of appeal information:

- UM appeal requests from members or their authorized representatives.
- UM appeal request receipt date.
- Substance and investigation of an appeal.
- UM appeal participants, as applicable.
  - Individual or group (e.g., panel) deciding the appeal.
  - Appropriate practitioner.
  - Same-or-similar-specialist review.
- UM appeal notice.
- UM appeal decision notification date.

The organization defines the dates of receipt and written notification for UM appeal decisions regarding coverage, whether or not a denial resulted from medical necessity review, consistent with the requirements in UM 8 and UM 9.

Factor 2: **Staff responsible for performing UM activities**

The organization's policies and procedures specify titles of staff who are:

- Responsible for documenting completion of UM activities.
- Authorized to modify (edit, update, delete) UM information.
  - Policies and procedures state if no staff are authorized to modify dates under any circumstances.
- Responsible for oversight of UM information integrity functions, including the audit.

Factor 3: **Process for documenting updates to UM information**

The organization's policies and procedures:

- Specify when updates to UM information are appropriate (e.g., the member sends an update request).
- Describe the organization's process for documenting the following when updates are made to UM information:
  - When (e.g., date and time) the information was updated.

- What information was updated.
- Why the information was updated.
- Staff who updated the information.

Factor 4: **Inappropriate documentation and updates**

The organization's policies and procedures:

- Specify that the following documentation and updates are inappropriate:
  - Falsifying UM dates (e.g., receipt date, appeal decision date, appeal notification date).
  - Creating documents without performing the required activities.
  - Fraudulently altering existing documents (e.g., investigation information, same-or-similar specialist review, appeal notices).
  - Attributing review to an individual who did not perform the activity.
  - Updates to information by unauthorized individuals.

Factor 5: **Auditing, documenting and reporting information integrity issues**

The organization's policies and procedures:

- Specify that the organization audits UM staff documentation and updates.
  - The policies and procedures do not have to include the audit methodology, but must indicate that an annual audit is performed.
- Describe the process for documenting and reporting inappropriate documentation and updates to:
  - The organization's designated individual(s) when identified.
  - NCQA, when the organization identifies fraud and misconduct.
    - Refer to Section 5 *(Reporting Hotline for Fraud and Misconduct; Notifying NCQA of Reportable Events)* in the Policies and Procedures for details.
  - Specify consequences for inappropriate documentation and updates.

Exception

None.

Examples None.

Element C: Information Integrity Training

The organization annually trains UM staff on:

1. **Inappropriate documentation and updates (Elements A and B, factor 4).**
2. **Organization audits of staff, documenting and reporting information integrity issues (Elements A and B, factor 5).**

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~

~~The organization meets 2 factors~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization meets 0-1 factors~~

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

Data source Reports, Materials

Scope of review NCQA reviews training materials and evidence that the organization conducted the required training.

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

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

Factor 1: **Inappropriate documentation and updates**

The organization trains UM staff on inappropriate documentation and updates to UM information, as defined in Elements A and B, factor 4.

Factor 2: **Auditing, documenting and reporting information integrity issues**

The organization's training informs UM staff of:

- Organization audits of staff documentation and updates in UM files.
- The process for documenting and reporting inappropriate documentation and updates to:
  - The organization's designated individual(s) when identified.
  - NCQA, when the organization identifies fraud and misconduct.
- The consequences for inappropriate documentation and updates.

Exceptions

None.

Examples None.

Element D: Audit and Analysis—Denial Information

The organization annually:

1. **Audits for inappropriate documentation and updates to UM denial receipt and notification dates.**
2. **Conducts qualitative analysis of inappropriate documentation and updates to UM denial receipt and notification dates.**

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 2 factors~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization meets 0-1 factors~~

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

Data source
Reports

Scope of review
NCQA reviews the organization's audit and analysis reports completed during the look-back period.

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

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

Factor 1: **Audit**

The organization annually audits for inappropriate documentation and updates to:

- UM request receipt dates (UM 5).
- UM denial decision notification dates (UM 5, UM 7).

The organization defines the dates of receipt and notification for UM denial determinations resulting from medical necessity review, consistent with the requirements in UM 5.

The audit universe includes files for UM denial decisions (based on the denial decision notification date) made during the look-back period. The organization randomly samples and audits 5% or 50 files, whichever is less, from the file universe. The organization may choose to audit more UM denial files than NCQA requires.

The organization provides an auditing and analysis report that includes:

- The report date.
- The titles of the individuals who conducted the audit.
- The 5% or 50 files auditing methodology.
  - Auditing period.
  - File audit universe size (described in the paragraph above).
  - Audit sample size.
- The audit log (as a referenced attachment)
  - The file identifier (case number).
  - The types of dates audited (i.e., receipt date, notification date).
  - Findings for each file.
  - A rationale for each instance of inappropriate documentation or updates.
- The number or percentage and total number or percentage of inappropriate findings by date type.

The organization must provide a completed audit report even if no inappropriate documentation and updates were found.

Factor 2: **Qualitative analysis**

The organization annually conducts qualitative analysis of each instance of inappropriate documentation and update identified in the audit (factor 1) to determine the cause.

The organization's auditing and analysis report also includes:

- Titles of UM staff involved in the qualitative analysis.
- The cause of each finding.

Refer to *Appendix 5: Glossary* for the full definition of qualitative analysis.

Exceptions

Factor 2 is NA if the organization did not identify any inappropriate documentation and updates (factor 1). NCQA assesses whether this conclusion is reasonable, based on results of the organization's analysis.

Related information

If the organization audits more frequently, it must use the "5% or 50 files" methodology for each audit, and all audits must cumulatively cover the 12-month look-back period.

If the organization's system automatically records receipt and decision notification dates, and does not permit changes under any circumstances, the organization may, in lieu of completing a full audit and analysis report, generate, review and submit a complete system log showing there were no changes to dates during the look-back period. The organization may audit using the NCQA 5% or 50 files methodology. The organization audit and analysis report includes the following:

- Evidence that the organization's UM system automatically records receipt and decision notification dates, and does not permit changes under any circumstances.
- The report date.
- The title of the individual(s) who conducted the audit/review.
- Auditing/review period.
- File universe.
- Sampling methodology, if applicable.
- System generated log showing there were no changes to dates.

A separate analysis is not required if no dates were changed. If the audit reveals dates were changed, an analysis is required.

Examples

Factors 1, 2: **Audit and analysis report**

[Organization's Name]—Annual UM Information Integrity Assessment Report

The report date: February 10, [current year].

Auditor: [Individual's Name], UM Director

Auditing methodology: Each January, the UM director audits a random sample of UM denial files for inappropriate documentation and updates to UM request receipt dates (UM 5) and denial decision notification dates (UM 7) for the previous calendar year. The audit sample includes 5% or 50 files (whichever is less) randomly selected (based on the denial decision notification date) from all UM

denial decisions made in the previous calendar year.

- Period reviewed: January 1-, [previous year]– December 31 [previous year].
- File-review universe size: 1,500 UM denial decisions based on medical necessity review were made during the review period.
- Audit sample size calculation: 1,500 UM denial files x 0.05 = 75 files.
- Audit sample size: 50 files, which is less than the 5% (75 files).

Audit date: January 6–9, [current year]

Audit log: Attachment 1. Partial illustration in table below.

Case ID	Inappropriate Documentation/Updates?		Finding From Audit Period
	Receipt Date	Notification Date	
1235	No	No	NA
1245	Yes	Yes	Receipt and notification dates updated by [Staff Name] on 3/4/[previous year] @ 2:59 PM after denial notice was sent.
1255	No	No	NA
1265	No	No	NA
1275	Yes	Yes	Receipt and notification dates updated by [Staff Name] on 3/4/[previous year] @ 3:40 PM after denial notice was sent.
1285	Yes	Yes	Receipt and notification dates updated by [Staff Name] on 3/4/[previous year] @ 4:00 PM after denial notice was sent.

Summary of findings:

Date Type	Compliant Denial Files	Noncompliant Denial Files	Total	Percentage of Noncompliant Denial Files
UM request receipt date	35	15	50	30%
UM denial notification date	35	15	50	30%

Qualitative analysis. The UM director provided the UM staff with the audit log documenting how, when, and by whom files were updated.

The UM director held a series of meetings (January 14–17, [current year]) with UM staff (UM assistant director, UM manager, UM analyst) to determine the causes of each inappropriate update to UM request receipt and denial notification dates. The causes of the inappropriate updates are outlined in the table below.

Date Type	Description of Noncompliant Update	Reason
UM request receipt date	All 15 receipt dates were improperly updated in the UM denial file by the same staff on 3/4/[previous year], after a decision had been sent.	Receipt dates were improperly updated because the urgent concurrent decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/11/[previous year]. Staff felt internal pressure to pass the state audit at any cost.

Date Type	Description of Noncompliant Update	Reason
UM denial notification date	All 15 notification dates were improperly updated by the same staff on 3/24/[previous year], after a decision had been sent.	Notification dates were improperly updated because the urgent concurrent decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/11/[previous year]. Staff felt internal pressure to pass the state audit at any cost.

Element E: Improvement Actions—Denial Information

The organization:

1. **Implements corrective actions to address all inappropriate documentation and updates found in Element D.**
2. **Conducts an audit of the effectiveness of corrective actions (factor 1) on the findings 3–6 months after completion of the annual audit in Element D.**

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 2 factors~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization meets 0-1 factors~~

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

Data source Documented process, Reports, Materials

Scope of review *For Initial and Renewal Surveys:*

- *For factor 1:* NCQA reviews the organization's documentation of corrective

actions planned or taken to address inappropriate documentation and updates.

- *For factor 2:* NCQA reviews the organization's audit of the effectiveness of corrective actions.

Look-back period

For Initial and Renewal Surveys: At least once during the prior year.

Explanation

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

The organization addresses UM information integrity issues identified in Element D.

***Factor 1:* Implement corrective actions**

The organization documents all actions taken or planned, including the time frame for actions, to address all inappropriate documentation and updates (findings) identified in Element D. One action may address more than one finding, if appropriate. Annual trainings (Element C) may not be the only corrective action.

The organization identifies the staff (by title) who are responsible for implementing corrective actions.

***Factor 2:* Measure effectiveness follow-up audit**

The organization audits the effectiveness of corrective actions (factor 1) on findings within 3–6 months of the annual audit completed for Element D. The audit universe includes 3–6 months of UM denial files processed by the organization since the annual audit completed for Element D.

The organization conducts a qualitative analysis if it identifies integrity during the follow-up audit.

The organization draws conclusions about the actions' overall effectiveness.

Exceptions

This element is NA if the organization did not identify any inappropriate documentation and updates to UM denial receipt and decision notification dates. This must be evident in reports reviewed for Element D.

Factor 2 is NA if the annual audit is less than 3 months before the organization's NCQA Survey.

Related information

If the organization's system automatically records receipt and decision notification dates, and does not permit changes under any circumstances, the organization may use the specified methodology and submit a system log showing no changes were made to dates. A separate qualitative analysis is not required if the system log demonstrates that no dates were changed.

Examples

***Factor 1:* Implement corrective actions**

[Organization's Name] UM director shared the audit analysis results and mitigation recommendations with the organization's leadership on January 31, [current year]. [Organization's Name] leadership required immediate implementation of actions and completion of all corrective actions, in the table below, on or before the dates specified.

UM Information/ Noncompliant Update	Reason	Correction Actions Planned
UM request receipt dates: UM staff member improperly updated request receipt dates in 15 UM denial files on 3/4/[previous year], after a decision had been sent.	Receipt dates were improperly updated because the urgent concurrent decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/11/[previous year]. Staff felt internal pressure to pass the state audit at any cost.	All UM staff must undergo ethics training, with emphasis on UM information integrity 4/15/[current year]. Owner: UM director. Update UM system to read only records for dates and other UM information by 6/1/[current year]. Owner: UM director. Establish process for two-step verification of system dates to records/information prepared for external review bodies by 5/1/[current year]. Owner: IT director.
UM denial notification dates: UM staff member improperly updated decision notification dates in 15 UM denial files on 3/4/[previous year], after a decision had been sent.	Receipt dates were improperly updated because the urgent concurrent decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/11/[previous year]. Staff felt internal pressure to pass the state audit at any cost.	

Factor 2: **Effectiveness of corrective actions report**

[Organization's Name]—Annual UM Information Integrity Measure of Effectiveness

Report date: August 30, [current year]

Auditor: [Individual's Name], UM director

Auditing methodology: [Organization Name] audits the effectiveness of corrective actions taken within 6 months of the annual audit completed on January 6–9, [current year], by randomly selecting a sample of 5% or 50 files from all UM denial decisions (based on the denial decision notification date) since the last annual audit.

- Period reviewed: February [current year]– July [current year].
- File-review universe size: 750 UM denial decisions was made during the review period.
- Audit sample size calculation: 750 UM denial files x 0.05 = 37.5 files (38 files).
- Audit sample size: 38 files, which is less than the 5% (75 files).

Audit date: July 11–15, [current year].

Audit log: Attachment 1. (Not shown in this example).

Summary of findings:

Date Type	Compliant Denial Files	Noncompliant Denial Files	Total	Percentage of Noncompliant Denial Files
UM request receipt date	38	0	38	0%
UM denial notification date	38	0	38	0%

Qualitative analysis: Not required.

Actions effectiveness:

Noncompliant UM Updates January [year] Audit	Corrective Actions Completed	Action Effectiveness July [year] Audit
UM request receipt dates: UM staff improperly updated request receipt dates in 15 UM denial files on 3/4/[previous year], after a decision had been sent.	All UM staff completed ethics training, with emphasis on following UM information integrity policies and procedures on 4/15/[current year]. UM system updated to read only records for dates and all other UM information was completed 6/1/[current year]. Approved established process for two-step verification of system dates to records/information prepared for external review bodies on 5/1/[current year].	There were no incidences of UM denial receipt or notification dates updates found in the audit sample. The implementation of read-only data in the UM system was tested during the audit and functioned properly. The two-process verification was tested for the upcoming Department of Insurance assessment which was scheduled for August [current year]. All records prepared for external review matched information in the UM system. No UM data were updated.
UM denial notification dates: UM staff improperly updated decision notification dates in 15 UM denial files on 3/4/[previous year], after a decision had been sent.		

Overall effectiveness—Conclusion

The corrective actions implemented were effective in preventing inappropriate documentation and updates based on follow-up assessment which showed that no incidences of inappropriate documentation and updates were made, and test results of the UM system read-only functionality and two-step verification proved the new features were working properly.

Element F: Audit and Analysis—Appeal Information

The organization annually:

1. **Audits for inappropriate documentation and updates to UM appeal receipt and notification dates.**
2. **Conducts qualitative analysis of inappropriate documentation and updates to UM appeal receipt and decision notification dates.**

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 2 factors~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization meets 0-1 factors~~

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

Data source Reports

Scope of review NCQA reviews the organization's audit and analysis report(s) completed during the look-back period.

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

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

This element applies to UM information (both paper and electronic) used in the UM appeal process (UM 8, UM 9).

Factor 1: **Audit**

The organization annually audits for inappropriate documentation and updates to:

- UM appeal request receipt dates.
- UM appeal decision notification dates.

The organization defines the dates of receipt and written notification for UM appeal decisions of coverage, whether or not an appeal resulted from medical necessity review, consistent with the requirements in UM 8 and UM 9.

The audit universe includes files for UM appeal decisions (based on the appeal decision notification date) during the look-back period. The organization randomly audits a sample of UM appeal files from the audit universe using 5% or 50 files, whichever is less. The organization may choose to audit more UM appeal files than NCQA specifies.

The organization provides an auditing and analysis report that includes:

- The date of the report.
- The title of staff who conducted the audit.

- The audit method:
  - Audit period.
  - Audit universe size (described in the paragraph above).
  - Audit sample size.
  - File identifier (case number).
  - Type of date audited (receipt date, notification date).
- Findings for each file.
- A rationale for each instance of inappropriate documentation or updates.
- The number or percentage and total inappropriate documentation and updates.

The organization must provide a completed audit report even if no inappropriate documentation and updates were found.

Factor 2: **Qualitative analysis**

The organization annually conducts qualitative analysis of each instance of inappropriate documentation and update identified in the audit (factor 1) to determine the cause. Analysis involves staff responsible for executing the UM denial or appeal process.

The organization's auditing and analysis report includes:

- Titles of UM staff involved in the analysis.
- The cause of each finding.

Refer to *Appendix 5: Glossary* for the full definition of qualitative analysis.

Exception

Factor 2 is NA if the organization did not identify any inappropriate documentation and updates (factor 1). NCQA assesses whether this conclusion is reasonable, based on results of the organization's analysis.

Related information

If the organization audits more frequently, it must use the "5% or 50 files" methodology for each audit, and all audits must cumulatively cover the 12-month look-back period.

If the organization's system automatically records receipt and decision notification dates, and does not permit changes under any circumstances, the organization may, in lieu of completing a full audit and analysis report, generate, review and submit a complete system log showing there were no changes to dates during the look-back period. The organization may audit using the NCQA 5% or 50 files methodology. The organization audit and analysis report includes the following:

- Evidence that the organization's UM system automatically records receipt and decision notification dates, and does not permit changes under any circumstances.
- The report date.
- The title of the individual(s) who conducted the audit/review.
- Auditing/review period.
- File universe.
- Sampling methodology, if applicable.
- System generated log showing there were no changes to dates.

A separate analysis is not required if no dates were changed. If the audit reveals dates were changed, an analysis is required.

Examples

Factors 1, 2: **Audit and analysis report**

[Organization's Name]—Annual UM Information Integrity Assessment Report

Report date: February 10, [current year].

Auditor: [Individual Name], UM director

Auditing methodology: Each January, the UM director audits a random sample of UM appeal files for inappropriate documentation and updates to UM appeal receipt dates and UM appeal decision notification dates for the previous calendar year. The audit sample includes 5% or 50 files (whichever is less) randomly selected from all UM appeal decision notifications made in the previous year.

- Period reviewed: January 1, [previous year]– December 31 [previous year].
- File-review universe size: 1,500 UM appeal decisions was made during the review period.
- Audit sample size calculation: 1,500 UM appeal files x 0.05 = 75 files.
- Audit sample size: 50 files, which is less than the 5% (75 files).

Audit date: January 6–-9 [current year].

Audit log: Attachment 1. Partial illustration in table below.

Case ID	Inappropriate Documentation/Updates?		Finding
	Receipt Date	Notification Date	
1235	No	No	NA
1245	Yes	Yes	Receipt and notification dates updated by [Staff Name] on 3/4/[previous year] @ 2:59 PM after appeal notice was sent.
1255	No	No	NA
1265	No	No	NA
1275	Yes	Yes	Receipt and notification dates updated by [Staff Name] on 3/4/[previous year] @ 3:40 PM after appeal notice was sent.
1285	Yes	Yes	Receipt and notification dates updated by [Staff Name] on 3/4/[previous year] @ 4:00 PM after appeal notice was sent.

Summary of findings:

Date Type	Compliant Appeal Files	Noncompliant Appeal Files	Total	Percentage of Noncompliant Appeal Files
UM appeal request receipt date	35	15	50	30%
UM appeal notification date	35	15	50	30%

Qualitative analysis. The UM director provided staff with the audit log documenting how, when, and by whom files were updated.

The UM director held a series of meetings (January 14–-17, [current year].) with UM staff (UM assistant director, UM manager, UM analyst) to determine the causes of each inappropriate update to UM appeal receipt and notification dates. The causes of the inappropriate updates are outlined in the table below.

Date Type	Description of Noncompliant Update	Reason
UM appeal request receipt date	All 15 appeal request receipt dates were improperly updated in the UM appeal file by the same staff on 3/4/[previous year], after a decision had been sent.	Receipt dates were improperly updated because the expedited appeal decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/11/[previous year] Staff felt internal pressure to pass the state audit at any cost.
UM appeal notification date	All 15 appeal notification dates were improperly updated by the same staff on 3/24/[previous year], after a decision had been sent.	Notification dates were improperly updated because the expedited appeal decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/11/[previous year] Staff felt internal pressure to pass the state audit at any cost.

Element G: Improvement Actions—Appeal Information

The organization:

1. **Implements corrective actions to address all inappropriate documentation and updates found in Element F.**
2. **Conducts an audit of the effectiveness of corrective actions (factor 1) on findings 3–6 months after completion of the annual audit for Element F.**

Summary of Changes

- Adjusted scoring to “Met,” “Partially Met” and “Not Met.”

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 2 factors~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization meets 0-1 factors~~

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

Data source
Scope of review

Documented process, Reports, Materials
For Initial and Renewal Surveys:

- *For factor 1:* NCQA reviews the organization's documentation of corrective actions planned or taken to address inappropriate documentation and updates.
- *For factor 2:* NCQA reviews the organization's audit of the effectiveness of corrective actions.

Look-back period

For Initial and Renewal Surveys: At least once during the prior year.

Explanation

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

This element applies to UM information (both paper and electronic) used in the UM appeal process (UM 8, UM 9).

Factor 1: **Implement corrective actions**

The organization documents all actions taken or planned to address all inappropriate documentation and updates (findings) identified in Element F. One action may be address more than one finding, if appropriate. The organization may not use annual training (Element C) as the only action.

The organization identifies staff (by title) who are responsible for implementing corrective actions.

Factor 2: **Measure of effectiveness follow-up audit**

The organization audits the effectiveness of corrective actions (factor 1) on findings within 3–6 months of the annual audit completed for Element F, and draws conclusions about the actions' overall effectiveness. The audit universe includes 3–6 months of UM appeal files processed since the annual audit.

The organization conducts a qualitative analysis if it identifies noncompliance with integrity policies and procedures during the follow-up audit.

Exceptions

This element is NA if the organization did not identify any inappropriate documentation and updates. This must be evident in reports reviewed for Element F.

Factor 2 is NA if the annual audit is less than 3 months before the organization's NCQA Survey.

Related information

If the organization's system automatically records receipt and decision notification dates, and does not permit changes under any circumstances, the organization may use the specified methodology and submit a system log showing no changes were made to dates. A separate analysis is not required if no dates were changed.

Examples

Factor 1: **Corrective actions**

[Organization Name's] UM director shared audit analysis results and mitigation recommendations with the organization's leadership on January 31, [current year]. [Organization's Name] leadership required immediate implementation of actions and completion of all corrective actions on or before the dates outlined in the table below.

UM Information/ Noncompliant Update	Reason	Correction Actions Planned
UM appeal request receipt dates: UM staff member improperly updated request receipt dates in 15 UM appeal file on 3/4/[previous year], after a decision had been sent.	Receipt dates were improperly updated because the expedited appeal decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/11/[previous year]. Staff felt internal pressure to pass the state audit at any cost.	All UM staff undergo ethics training, with emphasis on following UM information integrity policies and procedures by 4/15/[current year]. Owner: UM director. Update UM system to read only records for dates and other UM information by 6/1/[current year]. Owner: Information System director. Establish process for two-step verification of system dates to records/information prepared for external review bodies by 5/1/[current year]. Owner UM director
UM appeal notification dates: UM staff improperly updated decision notification dates in 15 UM appeal file on 3/4/[previous year], after a decision had been sent.	Notification dates were improperly updated because the expedited appeal decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/11/[previous year] Staff felt internal pressure to pass the state audit at any cost.	

Factor 2: **Measure effectiveness**

[Organization's Name]—Annual UM Information Integrity Measure of Effectiveness

Report date: August 30, [current year].

Auditor: [Individual's Name], UM director

Auditing methodology: [Organization Name] audits the effectiveness of corrective actions taken within 6 months of the annual audit completed on January [date, year]. The audit sample includes 5% or 50 files (whichever is less), randomly selected from all UM appeal decisions made by the organization since the last annual audit.

- Period reviewed: February [current year]– July [current year].

- File-review universe size: 750 UM appeal decisions made during the review period.
- Audit sample size calculation: 750 UM appeal files x 0.05 = 37.5 files (38 files).
- Audit sample size: 38 files, which is less than the 5% (75 files).

Audit date: July 11–-15, [current year].

Audit log: Attachment 1. (Not shown in this example).
Summary of findings:

Date Type	Compliant Appeal Files	Noncompliant Appeal Files	Total	Percentage of Noncompliant Appeal Files
UM request receipt date	38	0	38	0%
UM appeal notification date	38	0	38	0%

Qualitative analysis: Not required.

Actions effectiveness:

Noncompliant UM Updates January [year] Audit	Corrective Actions Completed	Action Effectiveness July [year] Audit
UM request receipt dates: UM staff improperly updated request receipt dates in 15 UM appeal file on 3/4/[previous year], after a decision had been sent.	All UM staff completed ethics training, with emphasis on following UM information integrity policies and procedures on 4/15/[current year]. UM system update to read only records for dates and all other UM information was completed 7/1/[current year]. Approved established process for two-step verification of system dates to records/ information prepared for external review bodies on 6/1/[current year].	There were no incidences of UM appeal receipt or notification dates updates found in the audit sample. The implementation of read-only data in the UM system was tested during the audit and is functioning properly. The two-process verification was tested for the upcoming Department of Insurance was scheduled for August [current year]. All records prepared for external review matched information in the UM system. There was no inappropriate updating of UM data.
UM appeal notification dates: UM staff improperly updated decision notification dates in 15 UM appeal file on 3/4[previous year], after a decision had been sent.		

Overall effectiveness—Conclusion

The corrective actions implemented were effective in preventing inappropriate documentation and updates based on follow-up assessment and that no incidences of inappropriate documentation and updates were made, and the test results of the UM system read-only functionality and two-step verification proved the new features were working properly.

UM 12: 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.

Element A: Delegation Agreement

The written delegation agreement:

1. **Is mutually agreed upon.**
2. **Describes the delegated activities and the responsibilities of the organization and the delegated entity.**
3. **Requires at least semiannual reporting by the delegated entity to the organization.**
4. **Describes the process by which the organization evaluates the delegated entity's performance.**
5. **Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.**

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 5 factors~~	~~The organization meets 4 factors~~	~~The organization meets 3 factors~~	~~The organization meets 1-2 factors~~	~~The organization meets 0 factors~~

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 Materials

Scope of review NCQA reviews delegation agreements in effect during the look-back period from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

For factor 4:

- New delegation agreements implemented on or after July 1, 2025, must address the delegate's UM information integrity.
- Delegation agreements in place prior to July 1, 2025, that address the system controls requirements under the 2022–2024 standards do not need to

be updated to address UM information integrity requirements. NCQA does not evaluate the agreement against prior system controls requirements.
- Delegation agreements in place prior to July 1, 2025, that do not address the system controls intent under the 2022–2024 standards must be updated prior to July 1, 2025, to address UM information integrity requirements.

The score for the element is the average of the scores for all delegates.

Look-back period

For Initial Surveys: 6 months for factors 1–5; prior to the survey date for the information integrity component under factor 4.

For Renewal Surveys: 24 months for factors 1**–**5; prior to the survey date for the information integrity component under factor 4.

Explanation

This element may not be delegated.

This element applies to agreements that are in effect within the look-back period. The delegation agreement describes all delegated UM activities. A generic policy statement about the content of delegated arrangements does not meet this element.

Factor 1: **Delegation agreement**

Delegation activities are mutually agreed on before delegation begins, in a dated, binding document or communication between the organization and the delegated entity.

NCQA considers the effective date specified in the delegation agreement as the mutually agreed-upon effective date. The effective date may be before or after the signature date on the agreement. If the agreement has no effective date, NCQA considers the signature date (the date of the last signature) as the mutually agreed upon effective date.

NCQA may accept other evidence of the mutually agreed-upon effective date: a letter, meeting minutes or other form of communication between the organization and the delegate that references the parties' agreement on the effective date of delegated activities.

NCQA requires submitted evidence for all other delegation factors to consider the same mutually agreed-upon date as the effective date for the delegate's performance of delegated activities.

Factor 2: **Assigning responsibilities**

The delegation agreement or an addendum thereto or other binding communication between the organization and the delegate specifies the UM activities:

- Performed by the delegate, in detailed language.
- Not delegated, but retained by the organization.

The organization may include a general statement in the agreement addressing retained functions (e.g., the organization retains all other UM functions not specified in this agreement as the delegate's responsibility).

If the delegate subdelegates an activity, the delegation agreement must specify that the delegate or the organization is responsible for subdelegate oversight.

Factor 3: **Reporting**

The organization determines the method of reporting and the content of the reports, but the agreement must specify:

- That reporting is at least semiannual.
- What information is reported by the delegate about delegated activities.
- How, and to whom, information is reported (i.e., joint meetings, or to appropriate committees or individuals in the organization).

The organization must receive regular reports from all delegates, even NCQA-Accredited or NCQA-Certified delegates.

Factor 4: **Performance monitoring**

The delegation agreement states the organization's process for monitoring and evaluating the delegate's performance, as required in Element C, including UM information integrity.

UM information integrity refers to maintaining and safeguarding information used in the UM denial decision process (UM 4–UM 7) and UM appeal process (UM 8–UM 9) against inappropriate documentation and updates, as outlined in UM 11, Elements A and B, factor 4.

If the organization delegates processing of UM requests covered in UM 4–UM 7, or UM appeal requests covered in UM 8–UM 9, the delegate protects the integrity of UM information used in the denial and appeal processing, as applicable. The delegation agreement specifies that the following documentation and updates to UM information are inappropriate:

- Falsifying UM dates (e.g., receipt date, UM decision date, notification date).
- Creating documents without completing the required activities.
- Fraudulently altering existing documents (e.g., clinical information, board certified consultant review, denial notices).
- Attributing review to someone who did not complete the activity (e.g., appropriate practitioner review).
- Updates to information by unauthorized individuals.

Factor 5: **Consequences for failure to perform**

The delegation agreement specifies consequences if a delegate fails to meet the terms of the agreement and, at a minimum, circumstances that would cause revocation of the agreement.

Exceptions

This element is NA if the organization does not delegate UM activities.
Factor 3 is NA for mail service organization delegates that only perform annual distribution. Factor 3 is not NA for distribution that occurs more frequently than annually (e.g., denial and appeal notices).

Related information

Outsourcing UM data storage to a cloud-based entity. It is not considered delegation if the organization only outsources UM data storage to a cloud-based entity that does not provide services that create, modify or use the UM data.

Examples

Factor 3: **Reporting for delegation of UM denials and appeals**

- Number of UM cases handled by type (preservice, urgent concurrent or postservice) and by service (inpatient or outpatient).

- Number of denials issued.
- Number of denials appealed.

Element B: Predelegation Evaluation

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization evaluated delegate capacity before delegation began~~	~~No scoring option~~	~~The organization evaluated delegate capacity after delegation began~~	~~No scoring option~~	~~The organization did not evaluate delegate capacity~~

Met	Partially Met	Not Met
The organization evaluated delegate capacity before delegation began	The organization evaluated delegate capacity after delegation began	The organization did not evaluate delegate capacity

Data source Reports

Scope of review NCQA reviews the organization's predelegation evaluation from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

The score for the element is the average of the scores for all delegates.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 12 months.

Explanation This element may not be delegated.

NCQA-Accredited delegates

For non-information integrity requirements, automatic credit is available for this element if all delegates are NCQA-Accredited health plans or MBHOs, or are NCQA Accredited in UM, unless the element is NA.

For information integrity requirements (UM 11, Elements A-G), automatic credit is available for this element if all delegates are NCQA-Accredited health plans or MBHOs, or are NCQA Accredited in UM under the 2025 standards and beyond, unless the element is NA.

Note: *For organizations that have both NCQA-Accredited and non-Accredited delegates:*

- *NCQA-Accredited delegates are eligible for automatic credit.*
- *Non-Accredited delegates are reviewed and scored accordingly.*

Predelegation evaluation

The organization evaluated the delegate's capacity to meet NCQA requirements within 12 months prior to implementing delegation. The evaluation may include a review of the delegate's structure, processes, and staffing in order to determine its capability to perform the delegated function.

NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date.

If the time between the predelegation evaluation and implementation of delegation exceeds the 12 months, the organization conducts another predelegation evaluation.

If the organization amends the delegation agreement to include additional UM activities within the look-back period, it performs a predelegation evaluation for the additional activities.

Exceptions

This element is NA if:

- The organization does not delegate UM activities.
- Delegation arrangements have been in effect for longer than the look-back period.

Related information

Use of collaborative. The organization may enter into a statewide collaboration to perform any or all of the following:

- Predelegation evaluation.
- Annual evaluation.
- Annual audit of files.

The collaborative must agree on the use of a consistent audit tool and must share data. Each organization is responsible for meeting NCQA delegation standards, but may use the shared data collection process to reduce burden.

Examples

Predelegation evaluation

- Site visit.
- Telephone consultation.
- Documentation review.
- Committee meetings.
- Virtual review.

Element C: Review of the UM Program

For arrangements in effect for 12 months or longer, the organization:

1. **Annually reviews its delegate's UM program.**
2. **Annually audits UM denials and appeals files against NCQA standards for each year that delegation has been in effect.**
3. **Annually evaluates delegate performance against NCQA standards for delegated activities.**

4. **Semiannually evaluates regular reports, as specified in Element A.**
5. **Annually audits each delegate's UM denial and appeal files for inappropriate documentation and inappropriate updates to request receipt dates and decision notification dates.**
6. **Implements a corrective actions for each delegate that addresses all inappropriate documentation and inappropriate updates found in factor 5.**
7. **Conducts an audit of the effectiveness of corrective actions (factor 6) on the findings for each delegate 3–6 months after completion of the annual audit for factor 5.**

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 6-7 factors~~	~~No scoring option~~	~~The organization meets 4-5 factors~~	~~No scoring option~~	~~The organization meets 0-3 factors~~

Met	Partially Met	Not Met
The organization meets 6-7 factors	The organization meets 4-5 factors	The organization meets 0-3 factors

Data source

Documented process, Reports, Materials

Scope of review

NCQA reviews evidence of the organization's review from up to four randomly selected delegates, or all delegates if the organization has fewer than four.

For All Surveys: NCQA reviews the organization's evaluation of the delegate's UM program (factor 1).
For Initial Surveys: NCQA also reviews the organization's most recent semiannual evaluation, annual review, audits, performance evaluation, corrective actions and measure of effectiveness (factors 2–7).

For Renewal Surveys:

- *Factors 2–4:* NCQA also reviews the organization's most recent and the previous year's annual reviews, audits, performance evaluations and four semiannual evaluations.
- *Factors 5–7:* NCQA also reviews the organization's most recent annual audit, performance evaluation, corrective actions and measure of effectiveness.

The score for the element is the average of the scores for all delegates.

Look-back period

For Initial Surveys: Once during the prior year.

For Renewal Surveys: 24 months for factors 1–4; at least once during the prior year for factors 5–7.

Explanation

This element may not be delegated.

NCQA-Accredited delegates

Automatic credit is available for factors 2 and 3 if all delegates are NCQA-Accredited health plans or MBHOs, or are NCQA Accredited in UM, unless the element is NA.

For factors 5–7, automatic credit is available if all delegates are NCQA-Accredited under the 2025 standards (or later) for Health Plan Accreditation, MBHO Accreditation or UM-CR-PN Accreditation, unless the element is NA.

Note: *For organizations that have both NCQA-Accredited and non-Accredited delegates:*

- *NCQA-Accredited delegates are eligible for automatic credit.*
- *Non-Accredited delegates are reviewed and scored accordingly.*

Factor 1: **Review of the UM program**

The appropriate organization staff or committee review the delegate's UM program. At a minimum, the organization reviews parts of the UM program that apply to the delegated functions.

Factor 2: **Annual file audit**

If the organization delegates the denial and appeal processes, it audits denial and appeal files against NCQA standards.

Note: *The organization may use the same file sample for factors 2 and 5, if applicable.*

The organization uses one of the following to audit the delegate's files:

- 5% or 50 files, whichever is less, ***or***
- The NCQA "8/30 methodology," available at http://www.ncqa.org/Programs/Accreditation/PolicyUpdatesSupportingDocuments.aspx

The organization bases its annual audit on the responsibilities described in the delegation agreement and the appropriate NCQA standards.

For mail service delegates only, the organization may submit the delegate's timeliness report of mail distribution in lieu of an audit.

Factor 3: **Annual evaluation**

No additional explanation required.

Factor 4: **Evaluation of reports**

No additional explanation required.

Factor 5: **Annual audit of UM information integrity**

If the organization delegates processing of UM requests covered in UM 4–UM 7, or UM appeal requests covered in UM 8–UM 9, the organization or the delegate annually audits (as applicable) the delegate's UM denial and appeal files separately for inappropriate documentation and inappropriate updates to:

- UM request receipt dates (UM 5).
- UM denial decision notification dates (UM 5, UM 7).
- UM appeal request receipt dates (UM 8, UM 9).
- UM appeal decision notification dates (UM 8, UM 9).

Note: *The organization may use the same file sample for factors 2 and 5, if applicable.*

For each delegate, the audit universe includes UM denial and appeal files (based on the denial and appeal decision notification dates) processed by the delegate during the look-back period.

If the organization conducts the annual audit, it audits each delegate using one of the following methods:

- 5% or 50 files, whichever is less, ***or***
- The NCQA "8/30 methodology" available at https://www.ncqa.org/programs/health-plans/policy-accreditation-and-certification/

Either methodology is allowed, for consistency with other delegation oversight requirements for annual information integrity audits.

A delegate that conducts the annual audit has two audit options.

Option 1: Audit each client using one method:

- "5% or 50 files" *or*
- The NCQA "8/30" method.

Option 2: Conducts one audit across all clients if the delegate uses the same staff, policies and procedures and UM system for all clients. In this case:

- The delegate must demonstrate that the same staff, policies and procedures and UM system are used for all clients.
- The audit universe includes UM denial and appeal files (based on the denial and appeal decision notification dates) processed by the delegate for all clients during the look-back period.
- The delegate must audit using the "5% or 50 files" methodology.

The organization or delegate may choose to audit more UM denial and appeal files than NCQA specifies.

The organization provides an auditing and analysis report that includes:

- The date of the report.
- Titles of staff who conducted the audit.
- The audit methodology:
  - "5% or 50 files" or "8/30," as applicable.
  - Audit period.
  - Audit universe size.
  - Audit sample size.
- File identifier (case number).
- Type of dates audited (receipt date, notification date).
- Findings for each file.
- A rationale for each instance of inappropriate documentation or update.
- The number or percentage and total inappropriate documentation and updates by date type.

The delegate or organization must provide a completed audit report even if no inappropriate findings were found.

If the organization uses the delegate's audit results, it must provide evidence (e.g., report, meeting minutes) that it reviewed and evaluated the delegate's findings.

Factor 6: **Implement corrective actions**

The organization or the delegate may implement corrective actions.

For each delegate with inappropriate documentation and updates (findings) identified in factor 5, the organization documents corrective actions taken or planned, including the time frame for actions, to address all findings identified in factor 5. One action may be used to address more than one finding, if appropriate.

The organization or delegate's corrective action plan identifies staff (by title who are responsible for implementing corrective actions.

The organization reviews (e.g., report, meeting minutes) and approves a corrective action plan developed and implemented by a delegate.

Factor 7: **Measure effectiveness follow-up audit**

The organization or delegate audits the effectiveness of corrective actions (factor 6) on findings for each delegate within 3–6 months of the annual audit completed for factor 5.

For each delegate, the audit universe includes 3–6 months of UM denial and appeal files processed by the delegate since the annual audit. Denial and appeal files are audited separately.

The organization or delegate conducts a qualitative analysis if it identifies integrity issues during the follow-up audit.

If the organization uses the delegate's audit results, the organization must provide evidence (e.g., a report, meeting minutes, other evidence) that it reviewed and evaluated the delegate's findings.

The organization draws conclusions on the actions' overall effectiveness.

Exceptions

This element is NA if:

- The organization does not delegate UM activities.
- Delegation arrangements have been in effect for less than 12 months.

Factor 1 is NA for mail service delegates.

Factors 3 and 4 are NA if a mail service delegate distributes information for an element with an annual frequency.

- Factors 3 and 4 are not NA for distribution that occurs more frequently than annually (e.g., denial and appeal notices).

Factors 5–7 are NA for mail service delegates that:

- Do not have access to the organization's UM system.
- Do not have a UM system of their own.
- Do not modify or store the UM data sent by the organization.

Factors 6 and 7 are NA if the organization's audit of all delegates' denial and appeal files did not identify any inappropriate documentation or updates to receipt dates and decision notification dates. This must be evident in reports reviewed for factor 5.

Factor 7 is NA if the timing of the organization's annual audit is less than 3 months before the organization's NCQA Survey.

Related information

Use of collaborative. The organization may enter into a statewide collaboration to perform any or all of the following:

- Predelegation evaluation.
- Annual evaluation.
- Annual audit of files.

The collaborative must agree on the use of a consistent audit tool and must share

data. Each organization is responsible for meeting NCQA delegation standards, but may use the shared data collection process to reduce burden.

For factor 5: If the delegate's system automatically records receipt and decision notification dates, and does not permit changes under any circumstances, the delegate may use the specified methodology and submit a system log showing no changes to dates. A separate analysis is not required if no dates were changed.

Examples

***Factor 5:* Audit and analysis report**

[Delegate Name]—Annual UM Information Integrity Assessment

Report date: January [date, current year].

Auditor: [Delegate's staff Name], UM director, [Delegate Name]

Auditing methodology: Each January, [Delegate Name] UM director audits a random sample UM denial files for inappropriate documentation and updates to UM denial receipt dates (UM 5) and notification dates (UM 7) for the previous calendar year. The audit sample includes 5% or 50 files (whichever is less) randomly select from all UM denial decisions made in the previous year.

- Period reviewed: January 1 – December 31 [previous year].
- File-review universe size: 1,500 UM denial decisions was made during the review period.
- Audit sample size calculation: 1,500 UM denial files x 0.05 = 75 files.
- Audit sample size: 50 files, which is less than 5% (75 files).
- *Audit date:* January 6–9, [current year]

Audit log: Attachment 1. Partial illustration in table below.

Case ID	Inappropriate Documentation/Updates?		Finding
	Receipt Date	Notification Date	
1235	No	No	NA
1245	Yes	Yes	Receipt and notification dates updated by [Staff Name] on 3/4/[previous year] @ 2:59 PM after denial notice was sent.
1255	No	No	NA
1265	No	No	NA
1275	Yes	Yes	Receipt and notification dates updated by [Staff Name] on 3/4/[previous year] @ 3:40 PM after denial notice was sent.
1285	Yes	Yes	Receipt and notification dates updated by [Staff Name] on 3/4/[previous year] @ 4:00 PM after denial notice was sent.

Summary of findings:

Date Type	Compliant Denial Files	Noncompliant Denial Files	Total	Percentage of Noncompliant Denial Files
UM request receipt date	35	15	50	30%
UM denial notification date	35	15	50	30%

Qualitative analysis. [Delegate's] UM director provided UM staff with the audit log documenting how, when, and by whom files were updated.

[Delegate Name] UM director held meetings (January 14–17, [current year]) with UM staff (UM assistant director, UM manager, UM analyst) to determine the causes of each inappropriate update to UM denial receipt and notification dates. The causes of the inappropriate updates are outlined in the table below.

Date Type	Description of Noncompliant Update	Reason
UM request receipt date	All 15 receipt dates were improperly updated in the UM denial file by the same staff on 3/4/[previous year], after a decision had been sent.	Receipt dates were improperly updated because the urgent concurrent decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/11/[previous year]. Staff felt internal pressure to pass the state audit at any cost.

Date Type	Description of Noncompliant Update	Reason
UM denial notification date	All 15 notification dates were improperly updated by the same staff on 3/24/[previous year], after a decision had been sent.	Notification dates were improperly updated because the urgent concurrent decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/11/[previous year]. Staff felt internal pressure to pass the state audit at any cost.

Factor 6: **Corrective actions**

[Delegate Name] UM director shared audit analysis results and mitigation recommendations with [Organization name] UM director on January 31, [current year]. [Organization's name] UM director and leadership reviewed the report provided by [Delegate Name] (minutes attached) and required [Delegate name] to implement immediate corrective actions and complete corrective actions on or before the dates, outlined in the table below.

UM Information/ Noncompliant Update	Reason	Correction Actions Planned
UM request receipt dates: UM staff improperly updated request receipt dates in 15 UM denial file on 3/4/[previous year], after a decision had been sent.	Receipt dates were improperly updated because the urgent concurrent decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/11/[previous year]. Staff felt internal pressure to pass the state audit at any cost.	All [Delegate] UM staff undergo ethics training, with emphasis on following UM information integrity policies and procedures by 4/15/[current year]. Owner: UM Director, [Delegate Name] [Delegate Name] to update UM system to read only records for dates and other UM information by 6/1/[current year]. Owner: Information System Director, [Delegate Name] [Delegate Name] to establish process for two-step verification of system dates to records/information prepared for external review bodies by 5/1/[current year]. Owner: UM Director, [Delegate Name]
UM denial notification dates: UM staff member improperly updated decision notification dates in 15 UM denial file on 3/4/[previous year], after a decision had been sent.	Notification dates were improperly updated because the urgent concurrent decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/11/[previous year]. Staff felt internal pressure to pass the state audit at any cost.	

Evidence of [Organization Name]'s review: Minutes attached (Not shown in example)

Factor 7: **Effectiveness of corrective actions**

[Delegate Name]—Annual UM Information Integrity Assessment

Report date: August 30, [current year]

Auditor: [Delegate's staff Name], UM director, [Delegate Name]

Auditing methodology: [Delegate Name] audits the effectiveness of corrective actions taken within 6 months of the annual audit completed on January [date, year]. The audit sample includes 5% or 50 files (whichever is less), randomly selected from all UM denial decisions made by [Delegate] since the last annual audit.

- Period reviewed: February [current year]– July [current year].
- File-review universe size: 750 UM denial decisions made during the review period.
- Audit sample size calculation: 750 UM denial files x 0.05 = 37.5 files (38 files).
- Audit sample size: 38 files, which is less than 5% (75 files).

Audit date: July 11-–15, [current year].

Audit log: Attachment 1. (Not shown in the example).

Summary of findings:

Date Type	Compliant Denial Files	Noncompliant Denial Files	Total	Percentage of Noncompliant Denial Files
UM request receipt date	38	0	38	0%
UM denial notification date	38	0	38	0%

Qualitative analysis: Not required.

Actions effectiveness:

Noncompliant UM Updates January [year] Audit	Corrective Actions Completed	Action Effectiveness July [year] Audit
UM request receipt dates: UM staff improperly updated request receipt dates in 15 UM appeal file on 3/4/[previous year], after a decision had been sent.	All UM staff completed ethics training, with emphasis on following UM information integrity policies and procedures on 4/15/[current year]. UM system update to read only records for dates and all other UM information was completed 7/1/[current year]. Approved established process for two-step verification of system dates to records/ information prepared for external review bodies on 6/1/[current year].	There were no incidences of UM appeal receipt or notification dates updates found in the audit sample. The implementation of read-only data in the UM system was tested during the audit and is functioning properly. The two-process verification was tested for the upcoming Department of Insurance was scheduled for August [current year]. All records prepared for external review matched information in the UM system. There was no inappropriate updating of UM data.
UM appeal notification dates: UM staff improperly updated decision notification dates in 15 UM appeal file on 3/4[previous year], after a decision had been sent.		

Overall effectiveness—Conclusion

[Delegate's Name] UM director shared follow-up audit analysis results with [Organization's Name] UM director on August 1, [current year]. [Organization's Name] UM director and leadership reviewed the report provided by [Delegate

Name] on August 15, [current year], which proved the new features were working properly (minutes attached), and concluded that the corrective actions implemented were effective in preventing inappropriate documentation and updates, based on test results of the UM system read-only functionality and two-step verification.

Evidence of [Organization's Name]'s review: Minutes attached (not shown in example).

Element D: Opportunities for Improvement

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years the organization identified and followed up on opportunities for improvement, if applicable.

Summary of Changes

- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization has acted on identified problems, if any, at least once in each of the past 2 years that the delegation arrangement has been in effect~~	~~No scoring option~~	~~The organization took inappropriate or weak action, or acted only in the past year~~	~~No scoring option~~	~~The organization has not acted on identified problems~~

Met	Partially Met	Not Met
The organization has acted on identified problems, if any, at least once in each of the past 2 years that the delegation arrangement has been in effect	The organization took inappropriate or weak action, or acted only in the past year	The organization has not acted on identified problems

Data source Documented process, Reports, Materials

Scope of review

For Initial and Renewal Surveys: NCQA reviews reports for opportunities for improvement from up to four randomly selected delegates, or from all delegates, if the organization has fewer than four, and for evidence that the organization took appropriate action to resolve issues.

For Initial Surveys: NCQA reviews the organization's most recent annual review and follow-up on improvement opportunities.

For Renewal Surveys: NCQA reviews the organization's most recent and previous year's annual reviews and follow-up on improvement opportunities.

The score for the element is the average of the scores for all delegates.

Look-back period

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

For Renewal Surveys: 24 months.

Explanation

This element may not be delegated.

This element does not apply to UM information integrity. Areas of improvement for information integrity are addressed in UM 12, Element C, factors 5-7.

NCQA-Accredited delegates

Automatic credit is available for this element if all delegates are NCQA-Accredited health plans or MBHOs, or are NCQA-Accredited in UM, unless the element is NA.

Note: *For organizations that have both NCQA-Accredited and non-Accredited delegates:*

- *NCQA-Accredited delegates are eligible for automatic credit.*
- *Non-Accredited delegates are reviewed and scored accordingly.*

Identify and follow-up on opportunities

The organization uses information from its predelegation evaluation, ongoing reports or annual evaluation to identify areas of improvement.

Exceptions

This element is NA if:

- The organization does not delegate UM activities.
- Delegation arrangements have been in effect for less than 12 months.
- The organization has no opportunities to improve performance.

NCQA evaluates whether this conclusion is reasonable, given assessment results.

Examples

None.

Member Experience

ME 1 ~~RR 1~~: Statement of Members' Rights and Responsibilities

The organization has a written policy that states its commitment to treating members in a manner that respects their rights, and its expectations of members' responsibilities.

Intent

The organization recognizes the specific needs of and maintains a mutually respectful relationship with members.

Element A: Rights and Responsibilities Statement

The organization's member rights and responsibilities statement specifies that members have:

1. **A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.**
2. **A right to be treated with respect and recognition of their dignity and right to privacy.**
3. **A right to participate with practitioners in making decisions about their health care.**
4. **A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.**
5. **A right to voice complaints or appeals about the organization or the care it provides.**
6. **A right to make recommendations regarding the organization's member rights and responsibilities policy.**
7. **A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.**
8. **A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.**
9. **A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.**

Summary of Changes

- This element was formerly RR 1, Element A.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 9 factors~~	~~The organization meets 6-8 factors~~	~~No scoring option~~	~~The organization meets 5 factors~~	~~The organization meets 0-4 factors~~

Met	Partially Met	Not Met
The organization meets 6-9 factors	No scoring option	The organization meets 0-5 factors

Data source Documented process, Materials

Scope of review NCQA reviews the organization's policies and procedures or rights and responsibilities statement that is in place throughout the look-back period.

Look-back period

For Initial Surveys: 6 months.

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 may not be delegated.

Factors 1–9

No additional explanation required.

Exceptions

This element is NA for indirect purchasers and nonemployer businesses in the following circumstances:

- If an employer buys behavioral healthcare services from a health plan, and the health plan delegates behavioral healthcare services to the MBHO, the MBHO does not have a direct contract with the payer; consequently, the employer is considered an indirect purchaser of the MBHO's services.
- If individuals purchase behavioral healthcare services from a health plan, and the health plan delegates behavioral healthcare services to the MBHO, the individuals who purchase the services do not have a direct contract with the payer and are not employers; consequently, the individuals are considered indirect purchasers and nonemployer businesses. Indirect purchasers may include nonemployer businesses.

Examples

None.

Element B: Distribution of Rights Statement

The organization distributes its member rights and responsibilities statement to the following groups:

1. **New members, upon enrollment.**
2. **Existing members, if requested.**
3. **New practitioners, when they join the network.**
4. **Existing practitioners, if requested.**

Summary of Changes

- <u>This element was formerly RR 1, Element B.</u>
- <u>Adjusted scoring to "Met," "Partially Met" and "Not Met."</u>

<u>Scoring</u>

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization~~	~~The organization~~	~~The organization~~	~~The organization~~	~~The organization~~

~~meets 4 factors~~	~~meets 3 factors~~	~~meets 2 factors~~	~~meets 1 factor~~	~~meets 0 factors~~

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

Scope of review

NCQA reviews organization materials containing the rights statement distributed to members at enrollment and to practitioners who joined the network during the look-back period.

NCQA also reviews the organization's distribution of materials containing the rights statement to existing members and practitioners during the look-back period, if requested.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

FACTORS 1 AND 2 ARE CORE REQUIREMENTS. The organization must meet these requirements even if it does not have any clients or serve as a delegate.

The organization notifies members and practitioners of policy revisions as they occur.

Distribution of the rights statement

The organization distributes information to members and practitioners by mail, fax or email, or on its website if it informs members and 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 the information to members and practitioners who do not have fax, email or internet access.

Factors 1, 3

No additional explanation required.

Factors 2, 4

The organization provides documentation of an instance in the look-back period when it distributed the rights and responsibilities statement to a member and practitioner upon request. If the organization had no requests, it states so in writing as part of its survey submission. The organization is not required to track requests for existing members and practitioners during the look-back period in order to demonstrate the fact that there are no requests.

Documentation that the organization distributes the rights and responsibilities statement to all members and practitioners annually meets factors 2 and 4.

Exceptions

Factor 2 is NA if no existing members request the information.

Factor 4 is NA if no existing members request the information.

Factors 1 and 2 are NA if the organization presents documentation that all clients for the product lines being brought forward for Accreditation explicitly prohibit communication with members who have used the organization's services.

This element is NA for indirect purchasers and nonemployer businesses in the

following circumstances:

- If an employer buys behavioral healthcare services from a health plan, and the health plan that delegates behavioral healthcare services to the MBHO, the MBHO does not have a direct contract with the payer; consequently, the employer is considered an indirect purchaser of the MBHO's services.
- If individuals purchase behavioral healthcare services from a health plan, and the health plan delegates behavioral healthcare services to the MBHO, the individuals who purchase the services do not have a direct contract with the payer and are not employers; consequently, the individuals are considered indirect purchasers and nonemployer businesses. Indirect purchasers may include nonemployer businesses.

Related information

Use of vendors/mail service organizations for distribution of member rights and responsibilities statement. If the organization contracts with a mail service organization to provide distribution services, it provides access to the mail service organization's documentation for evaluation. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under *RR 5: Delegation of RR.* Refer to *Vendors* in *Appendix 3: Delegation and Automatic Credit Guidelines.*

Examples None.

ME 2: Subscriber Information (former RR 3)

The organization provides all subscribers with the information necessary to understand benefit coverage and obtain care.

Intent

The organization informs subscribers about benefits and access to behavioral healthcare services.

Element A: Subscriber Information

The organization's written subscriber information specifies:

1. **Benefits and services included in, and excluded from, coverage.**
2. **Copayments and other charges for which subscribers are responsible.**
3. **Benefit restrictions that apply to services obtained outside the organization's system or service area.**
4. **How to obtain language assistance.**
5. **How to submit a claim for covered services, if applicable.**
6. **How to obtain information about practitioners who participate in the organization.**
7. **How to obtain inpatient and outpatient services, partial hospitalizations and other behavioral healthcare services.**
8. **How to obtain subspecialty care.**
9. **How to obtain care after normal business hours.**
10. **How to obtain emergency care, including the organization's policy on when to directly access emergency care or use 911 services.**
11. **How to obtain care and coverage when subscribers are out of the organization's service area.**
12. **How to submit a complaint.**
13. **How to appeal a decision that adversely affects coverage, benefits or a subscriber's relationship with the organization.**
14. **Availability of independent, external review of internal UM final determinations.**

Summary of Changes

- This element is former RR 3, Element A.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 13-14 factors~~	~~The organization meets 12 factors~~	~~The organization meets 11 factors~~	~~The organization meets 9-10 factors~~	~~The organization meets 0-8 factors~~

Met	Partially Met	Not met
The organization meets 12-14 factors	The organization meets 11 factors	The organization meets 0-10 factors

Data source Materials

Scope of review

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

For Initial Surveys and Renewal Surveys: NCQA reviews the organization's subscriber information in place throughout the look-back period.

Look-back period

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

For Renewal Surveys: 24 months.

Explanation

This element may not be delegated, with the exception of factor 4, which may be delegated to an organization with NCQA Multicultural Health Care Distinction/ Health Equity Accreditation.

NCQA does not accept or review materials presented in draft form.

Information about subscriber benefits and services can be accessed easily and is written in user-friendly language.

Factor 1: **Benefits and services**

The written subscriber information explains the scope and limitations of benefits and services. The materials may include broad statements about exclusions (e.g., experimental or investigation services) without specifying the service or procedure, provided materials state that members have the opportunity to request information on excluded services or procedures and the organization maintains internal policies or criteria for these services or procedures.

Factors 2, 3

No additional explanation required.

Factor 4: **Language assistance**

The written subscriber information describes how the organization provides language services (through bilingual staff or interpreter services) to all subscribers who request them, to help subscribers obtain information about benefits and access to medical services.

Use of contracted translation services is not considered delegation.

Factor 5: **Claims for covered services**

No additional explanation required.

Factor 6: **Information about practitioners**

The written subscriber information tells subscribers how to obtain the following practitioner information:

- Name, address, telephone numbers.
- Professional qualifications.
- Specialty.
- Residency completion.
- Board certification status.

Factor 7: **Inpatient and outpatient services**

No additional explanation required.

Factor 8: **Subspecialty care**

The written subscriber information tells if subscribers are restricted from certain

specialists in its network.

***Factors 9, 10:* After-hours and emergent care**

No additional explanation required.

***Factor 11:* Care and coverage outside the service area**

The written subscriber information informs subscribers how to access services outside the service area and includes information on covered and noncovered benefits.

***Factor 12:* Submitting a complaint**

The written subscriber information instructs subscribers on submitting complaints verbally and in writing.

***Factor 13:* Appealing a decision**

The written subscriber information provides details about the organization's appeal process for coverage and noncoverage appeals and may include:

- Time frames for members to file an appeal.
- Time frames for deciding the appeal.
- Procedures for filing an appeal, including information to include and where to direct the appeal.

***Factor 14:* External review rights**

The written subscriber information provides written notification to subscribers of the availability of independent, external review of internal UM final determinations.

Exceptions

This element is NA if:

- The organization has NCQA-Accredited health plan business, indirect purchasers or nonemployer business brought forward for Accreditation.
- The organization presents documentation that all clients for the line of business being brought forward for Accreditation explicitly prohibit communication with members.

Factor 6 is NA if the organization does not process claims.

Factor 14 is NA for appeals:

- By members covered by Medicare, Medicaid or the Federal Employees Health Benefits (FEHB) Program.
- By members in self-funded accounts.

By members whose employer has arranged for employees to have access to employer-mandated independent review.

Examples

***Factors 1–14:* Sources of information for subscribers**

- Subscriber handbook.
- Practitioner and provider directory.
- Benefit summary materials.
- Subscriber ID card.

Element B: Distribution of Subscriber Information

The organization distributes its subscriber information to the following groups:

1. **New members, upon enrollment.**
2. **Existing members, annually.**

Summary of Changes

- This element is former RR 3, Element B.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 2 factors~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization meets 0-1 factors~~

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

Data source Reports, Materials

Scope of review

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

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

For Initial Surveys and Renewal Surveys: NCQA reviews evidence:

- That the organization distributed materials containing subscriber information to new members at enrollment during the look-back period.
- That the organization distributed materials containing subscriber information to existing members annually during the look-back period.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

Distribution of subscriber information

The organization distributes subscriber information by mail, fax or email.

The organization may include the information on its website if it informs subscribers that the information is available online and through alternative media on request. Notification must include a description specific enough to give readers a clear idea of the topic and general content of the site, and must include a link or direction to specific information. The organization may group or summarize the information by theme.

Factor 1

No additional explanation required.

Factor 2

The organization provides documentation that it distributes subscriber information to members annually.

Exceptions

This element is NA if:

- The organization has NCQA-Accredited health plan business, indirect purchasers or nonemployer business brought forward for Accreditation.
- The organization presents documentation that all clients for the line of business being brought forward for Accreditation explicitly prohibit communication with members.

For Initial Surveys, factor 2 is NA for organizations that:

- Did not have existing members for 12 months or more, and
- Provided subscriber information to all new members upon enrollment.

Related information

Use of vendors/mail service organizations for distribution of subscriber information. If the organization contracts with a mail service to distribute subscriber information, it provides access to the mail service's documentation for evaluation. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under *RR 5: Delegation of RR.* Refer to *Vendors* in *Appendix 3: Delegation and Automatic Credit Guidelines.*

Examples None.

Element C: Interpreter Services

Based on the linguistic need of its subscribers, the organization provides interpreter or bilingual services within its member services department and telephone functions.

Summary of Changes

- This element was formerly RR 3, Element C.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets the requirement~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization does not meet the requirement~~

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

Data source Reports, Materials, Records or files

Scope of review NCQA reviews an assessment of the subscribers' linguistic needs and contracts (or similar documents) for evidence that the organization provides services throughout the look-back period.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 24 months.

Explanation

Use of contracted language services is not considered delegation.

This element applies to organizations with subscribers whose principal spoken and written language is not English. The organization may use the linguistic data used to satisfy *QI 3: Availability of Practitioners and Providers*, Element A to meet this requirement.

Exception

The element is NA if the organization can show that all subscribers' principal spoken and written language is English.

Examples

Sources of data to determine linguistic needs

- Census Bureau data.
- Subscriber surveys.
- Information from employer groups.
- Analysis of subscriber complaints.
- For Medicaid and Medicare product lines, results of the *Race/Ethnicity Diversity of Membership (RDM)* and *Language Diversity of Membership (LDM)* HEDIS measures.

ME 3: Member Experience (former RR 2 and QI 5)

The organization has written policies and procedures for thorough, appropriate and timely resolution of member complaints and appeals.

Intent

The organization has a thorough and consistent process for addressing member complaints and appeals.

Element A: Policies and Procedures for Complaints

The organization has policies and procedures for registering and responding to oral and written complaints that include:

1. **Documentation of the substance of complaints and actions taken.**
2. **Investigation of the substance of complaints.**
3. **Notification to members of the resolution of complaint and, if there is an adverse decision, the right to appeal.**
4. **Standards for timeliness, including standards for urgent situations.**
5. **Provision of language services for the complaint process.**

Summary of Changes

- This element was formerly RR 2, Element A.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 5 factors~~	~~The organization meets 4 factors~~	~~The organization meets 3 factors~~	~~The organization meets 1-2 factor~~	~~The organization meets 0 factors~~

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

Scope of review NCQA reviews the organization's policies and procedures.

Look-back period *For Initial Surveys:* 6 months.

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.

This element applies to all complaints that do not become requests for coverage or to overturn a decision.

Complaints resolved during the first contact must be categorized as complaints and included in the analysis in *ME 3: Member Experience*, Element A, factors 1 and 2. ~~*QI 5: Member Experience*, Element A, factors 1 and 2.~~

Factor 1: **Documentation**

The organization's documentation of a complaint includes:

- The member's reason for making the complaint.
- Actions taken, including, but not limited to:
  - The member's previous complaint history.
  - Follow-up activities associated with the complaint.

Factor 2: **Investigation**

The organization investigates the content of a complaint, including all issues relevant to the complaint, and documents findings.

The organization's policies and procedures for resolving quality-of-care complaints specify when practitioner review is required.

Factor 3: **Notification of resolution and appeal rights**

Members have the right to appeal an adverse decision. If the organization makes an adverse decision as part of resolving a complaint, it notifies members of the decision and of their right to appeal.

If the organization cannot resolve a complaint within the time frame stated in its policies, or cannot notify the member of the final decision for legal or statutory reasons, at a minimum, it must notify the member that the complaint was received and investigated.

For the Medicare product line, the organization is not required to notify members of the right to appeal a grievance decision.

Factor 4: **Timeliness**

The organization sets timeliness standards for registering and responding to complaints. The organization's timeliness and notification standards consider urgency, as defined by the organization.

Factor 5: **Language services**

The organization provides language services through bilingual staff or interpreter services to help members through the complaint process.

Use of contracted translation services is not considered delegation.

Exceptions

None.

Examples

Factor 5: **Language services**

- Oral interpretation of documents written in English into a member's

preferred language.

- Member notification that documents are available in languages other than English.
- Language-line interpretation services are available for registering oral complaints.

Element B: Policies and Procedures for Appeals

The organization has policies and procedures for registering and responding to oral and written appeals of decisions that are not about coverage that include:

1. **Documentation of the substance of appeals and actions taken.**
2. **Investigation of the substance of appeals.**
3. **Notification to members of the disposition of appeals and the right to further appeal, as appropriate.**
4. **Standards for timeliness, including standards for urgent situations.**
5. **Provision of language services for the appeal process.**

Summary of Changes

- This element was formerly RR 2, Element B.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 5 factors~~	~~The organization meets 4 factors~~	~~The organization meets 3 factors~~	~~The organization meets 1-2 factor~~	~~The organization meets 0 factors~~

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

Scope of review NCQA reviews the organization's policies and procedures.

Look-back period *For Initial Surveys:* 6 months.

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.

"Appeal" in this element refers to appeals of decisions that are not about coverage. Appeals for coverage are assessed in *UM 8: Policies for Appeals* and *UM 9: Appropriate Handling for Appeals*. Members or their authorized representatives may appeal an adverse decision.

Factor 1: **Documentation**

The organization's documentation of the appeal includes:

- The member's reason for appealing the previous decision.
- Actions taken, including, but not limited to:
  - The member's previous appeal history.
  - Follow-up activities associated with the appeal.

Factor 2: **Investigation**

The organization investigates the content of the appeal, including all issues relevant to the appeal, and documents its findings.

Factor 3: **Notification of resolution and appeal rights**

The organization notifies members of its decision and of their right to appeal the resolution further within the time frame specified in its policies.

Factor 4: **Timeliness**

The organization sets timeliness standards for registering and responding to appeals. The organization's timeliness and notification standards consider urgency, as defined by the organization.

Factor 5: **Language services**

The organization provides language services through bilingual staff or interpreter services to help members through the appeal process.

Use of contracted translation services is not considered delegation.

Exception

This element is NA for the Medicare product line.

Examples

Appeals of decision that are not about coverage

- The organization denied a member's sixth request in 12 months to change primary care practitioners.
- A member's coverage was terminated for nonpayment of premium, but the member had cancelled checks as proof of payment.
- A member appealed the organization's payment to a practitioner because of a significant concern with the quality of care.
- A member whose primary language is not English requested language assistance. The organization denied the request, stating that the population of members who spoke the language was too small to support language assistance. The member appealed the decision.

Factor 5: **Language services**

- Oral interpretation of documents written in English into a member's preferred language.
- Member notification documents that are available in languages other than English.
- Language-line interpretation services for registering oral appeals.

Element C: Annual Assessment (former QI 5, Element A)

Using valid methodology, the organization annually:

1. **Evaluates member complaints and appeals for each of the five categories.**
2. **Conducts a member experience survey.**
3. ~~**Compiles and analyzes requests for and utilization of out-of-network services.**~~

Summary of Changes

- This element is former QI 5, Element A.
- Factor 3 is addressed in NET 3 and has been removed from this element.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 3 factors~~	~~No scoring option~~	~~The organization meets 2 factors~~	~~The organization meets 1 factor~~	~~The organization meets 0 factors~~

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

Data source

Reports

Scope of review

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

For Initial Surveys: NCQA reviews the organization's most recent annual data collection and member experience survey report.

For Renewal Surveys: NCQA reviews the organization's most recent and previous year's annual data collection and member experience survey reports. For factor 3, NCQA reviews the organization's most recent annual report.

The score for the element is the average of the scores for all product lines.

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.

Factor 1: **Member complaint and appeals**

The organization collects data for complaints and appeals separately.

The organization collects data on member complaints and appeals from the entire population or draws statistically valid samples from that population of members. If the organization uses a member sample, it describes the sample universe and the sampling methodology.

The organization collects data from all sources of member complaints and appeals including:

- Noncoverage appeals addressed in *RR 2: Policies and Procedures for Complaints and Appeals*.
- UM coverage appeals addressed in *UM 8: Policies for Appeals* and *UM 9: Appropriate Handling of Appeals*.

The organization aggregates all complaints and appeals into the following required categories:

- Quality of Care.
- Access.
- Attitude and Service.
- Billing and Financial Issues.
- Quality of Practitioner Office Site.

The organization may use a different coding system for its internal purposes, but for NCQA evaluation purposes, it must aggregate all complaint and appeal data in only the five reporting categories above.

The organization must report results on each category, even if there are no complaints or appeals for a category.

Factor 2: **Member experience survey**

The organization identifies the population, sample size, sampling technique, method of administration (e.g., telephone or mail, administered by an outside vendor or by the organization) and response rates.

The organization's report shows member experience results by product line, even if the response rate is low. A separate member experience survey for each product line is not required.

An experience survey that focuses on limited populations (e.g., hospitalized patients, users of partial hospitalization programs, members in a specific geographic area) does not meet the requirements of this element. The CAHPS survey does not meet this factor; however, supplemental survey questions regarding behavioral healthcare may meet this factor if a question identifies members who have accessed behavioral healthcare services.

Factor 3: **Requests for and utilization of out-of-network services**

The organization compiles data on member requests for out-of-network services and data on actual out-of-network utilization to identify and monitor issues with access to behavioral healthcare services practitioners and providers. The organization reports data per thousand members at the product line-level.

The organization conducts qualitative and quantitative analysis to identify possible causes of out-of-network requests and utilization, and opportunities to improve network adequacy.

Exceptions

This element is NA if the organization presents documentation that all clients for the product line being brought forward for Accreditation explicitly prohibit communication with members and will not provide member data to the organization. The organization must present documentation that it attempted to gather data from clients on member complaints and appeals related to its services and to member experiences with behavioral healthcare.

Noncoverage appeals are NA for the Medicare product line.

Examples

Complaint and appeal types

- *Quality of Care*

– A member filed a complaint that a condition was misdiagnosed.

- *Access*

– A member believed in-network practitioners did not have the expertise necessary to deal with an issue, and requested an out-of-network referral, which was denied. The member appealed the decision.

– Citing a shortage of Spanish-speaking practitioners, a member requested to go out of network. The request was denied and the member appealed the decision.

– A member filed a complaint that participating practitioners lacked available appointments.

- *Attitude and Service*

– A member complained that a practitioner was rude and used abusive language.

– A member complained about a wait time of 30 minutes to check out after an appointment.

– A member complained about the tone and attitude of the customer service representative.

– A member complained that a customer service representative provided inaccurate information.

- *Billing/Financial*

– Out-of-network services where members are balance billed.

– Disputes of deductibles and copayments.

- *Quality of Practitioner Office Site*

– A member sought out-of-network care because the participating practitioner's offices lacked wheelchair accessibility. The organization identified other practitioners with wheelchair access but the member appealed to go out of network.

Table 1: Annual complaint data (N = Complaints per 1,000 members)

Category	Previous Year	Current Year	Performance Goal	Performance Goal Met?
Quality of Care	4.50	4.07	<3.0	No
Access	3.31	4.36	<3.0	No
Attitude/Service	2.91	3.73	<3.0	No
Billing/Financial	2.51	2.42	<3.0	Yes
Quality of Practitioner Office Site	1.25	1.31	<3.0	Yes
Total Average	2.9	3.18	<3.0	NA

Table 2: Annual complaint data (N = Total member complaints)

Category	Previous Year	Current Year	Performance Goal (% Volume Reduction)	Percentage Change
Quality of Care	1,462	1,323	20%	-10%
Access	1,075	1,175	20%	9%
Attitude/Service	946	1,121	25%	18%
Billing/Financial	817	785	20%	-4%
Quality of Practitioner Office Site	431	413	20%	-4%
Total	4,310	4,817	20%	12%

Factor 3: **Requests for and utilization of out-of-network services**

UM reports

- Member/provider requests for out-of-network services, including:
  - Urgent concurrent, urgent preservice, nonurgent preservice and post-service requests.
  - Final determinations resulting from these requests (approvals and denials, regardless of reason code).
    - For PPO products, organizations may compile and analyze requests and final determinations for in-network level of benefit coverage.

Claims data

- Claims denied with the reason "services available in network" or other out-of-network indicator.
- For PPO products, organizations may compile and analyze claims paid with out-of-network cost sharing applied or at price tiers higher than the lowest cost-sharing level.
-

Element D: Scope of Survey (Former QI 5, Element B)

The organization's annual experience survey addresses at least the following factors:

1. **Services.**
2. **Accessibility.**
3. **Availability.**
4. **Acceptability.**

Summary of Changes

- This element was formerly QI 5, Element B.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 4 factors~~	~~No scoring option~~	~~The organization meets 3 factors~~	~~No scoring option~~	~~The organization meets 0-2 factors~~

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

Data source Materials

Scope of review NCQA reviews this element for each product line brought forward for Accreditation.

For Initial Surveys: NCQA reviews the organization's most recent annual survey.

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

The score for the element is the average of the scores for all product lines.

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 may not be delegated.

Survey methodology

The organization develops and distributes a survey with data collection methodology that is sound enough to produce valid and reliable results.

Experience surveys that focus on limited population (e.g., hospitalized patients, users of partial hospitalization programs, members in a specific geographic area) do not meet the requirements of this element.

The organization may measure experience across the full range of its operations.

Factor 1: **Services**

The organization assesses members' experience with the scope of behavioral healthcare services it offers.

Factor 2: **Access**

The organization assesses members' experience with easily obtaining behavioral healthcare services when they are needed.

Factor 3: **Availability**

The organization assesses members' experience with the presence or absence of the appropriate types of behavioral healthcare practitioners, providers and services in convenient locations.

Factor 4: **Acceptability**

The organization assesses members' experience with the "fit" of the behavioral healthcare practitioner offering care and with the program and services. The

member evaluates the organization on its capability to assess and meet special, cultural, ethnic, communication and linguistic needs and preferences expressed by members.

Exception

This element is NA if the organization presents documentation that all clients for the product line being brought forward for Accreditation explicitly prohibit communication with members.

Examples None.

Element D: Improvement Activities (former QI 5, Element C)

The organization works to improve members' experience by annually:

1. **Assessing data from complaints and appeals, member experience surveys and out-of-network service requests and utilization.**
2. **Identifying opportunities for improvement.**
3. **Implementing interventions.**
4. **Measuring the effectiveness of interventions.**

Summary of Changes

- This element was formerly QI 5, Element C.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 4 factors~~	~~The organization meets 3 factors~~	~~The organization meets 2 factors~~	~~The organization meets 1 factor~~	~~The organization meets 0 factors~~

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 *For Initial Surveys:* NCQA reviews the organization's most recent report, opportunities, interventions and effectiveness evaluations.

For Renewal Surveys: NCQA reviews the organization's most recent and previous year's reports, opportunities, interventions and effectiveness evaluations.

For factor 3: Depending on the action taken, NCQA also reviews a documented process.

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.

Factor 1: **Quantitative and qualitative analysis**

The organization analyzes data collected from complaint and appeal data (QI 5, Element A, factor 1), member survey data (QI 5, Element A, factor 2) and out-of-network service data (QI 5, Element A, factor 3).

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.

Refer to *Appendix 5: Glossary* for the full definition of and requirements for quantitative analysis and qualitative analysis.

Factor 2: **Identification of opportunities**

The organization identifies opportunities to pursue from its analysis of data. Identified opportunities are related directly to the findings of the qualitative analysis. The organization identifies opportunities by importance to member need or risk to member access to behavioral healthcare services.

Factor 3: **Implementing interventions**

Interventions are of sufficient strength and specificity that there is the likelihood they contribute to a measurable improvement and relate directly to causes of dissatisfaction identified in the analysis.

Factor 4: **Measuring effectiveness**

The organization measures the effectiveness of interventions to determine whether the interventions improved performance. Although demonstrating improvement is not required for this element, NCQA considers demonstrated improvements for inclusion in *QI 11*: *Effectiveness of the QI Program.*

The organization may measure effectiveness by repeating the original measurement or may use defined variables to measure performance of identified issues, collecting data on one of the following:

- Activities.
- Events.
- Occurrences.
- Outcomes.

Exceptions

This element is NA if the organization presents documentation that all clients for the product line being brought forward for Accreditation explicitly prohibit communication with members and will not provide member data to the organization. The organization must present documentation that it attempted to gather data from clients on member complaints and appeals related to its services and to member experiences with behavioral healthcare.

Factors 2, 3 and 4 are NA if the organization does not identify opportunities for improvement. NCQA evaluates whether this conclusion is reasonable, given assessment results.

Factor 4 is NA for Initial Surveys.

Examples

Factor 1: **Assessing out-of-network service data**

Based on its analysis of requests for and utilization of out-of-network requests, an organization found that in the last 12 months, 600 member requests related to out-

of-network services were processed through utilization management and 60 were processed through appeals. Most out-of-network activity was in an HMO plan, which represented 80% of all UM decisions and appeals. Most requests were approved, which indicates that there is a process in place to accommodate members in areas where the network lacks practitioners.

The organization is aware that there are various reasons why members might be requesting or obtaining out-of-network services, such as a lack or limited number of practitioners (e.g., behavioral healthcare subspecialists) in a geographic area; lack of member understanding about covered benefits and the referral process; primary care referral to an out-of-network specialist; services received by an out-of-network practitioner in a network facility; practitioner and facility directory inaccuracies; personal preference. Detailed analysis of denied requests showed that members in Southern California accessed out-of-network neuropsychiatrists most frequently.

Conducting quantitative analysis on member complaint data

The following table shows the aggregate complaint total and rate per 1,000 members for the past 2 years.

Category	Previous Year	Current Year
Quality of Care	1,462/4.50	1,323/4.07
Access	1,075/3.31	1,075/4.36
Attitude/Service	946/2.91	951/3.59
Billing/Financial	817/2.51	785/2.42
Quality of Practitioner Office Site	431/1.25	413/1.31
Total	4,310/13.26	4,134/14.44

The following table shows complaints calculated by percentage of the total for each category.

Category	Previous Year	Current Year
Quality of Care	34%	28%
Access	25%	30%
Attitude/Service	22%	25%
Billing/Financial	10%	10%
Quality of Practitioner Office Site	9%	7%

Causal analysis

The organization organized a causal analysis meeting with representatives from the Member Services, Provider Relations, QI and Claims departments to identify areas where goals were not met. The clinical director and assistant clinical director also participated. Results were as follows:

- Access to psychiatrists is an issue in specific geographic areas.
- Member Services scores declined. There was significant turnover in the department; in addition, the new telephone system had problems when it became operational.
- Cultural compatibility is a concern. This may be related to language issues; there has been an increase in complaints regarding the low number of practitioners who speak Spanish and Chinese.

Implementing interventions

- Recruit psychiatrists to areas where the member-to-practitioner ratio is below standard or arrange for remote access visits (e.g., telemedicine).
- Recruit Spanish and Chinese-speaking practitioners in areas with a large number of members who speak those languages and where the organization has received complaints.
- Train Member Services staff in communication skills.

The organization decided to focus its attention on recruiting psychiatrists and nonphysician practitioners with appropriate language skills to the service area where the language issues are the greatest, to help with access and communication issues.

ME 4: Delegation of ME (Former RR 5)

If the organization delegates ~~RR~~ ME activities, there is evidence of oversight of delegated activities.

Intent

The organization remains responsible for and has appropriate structures and mechanisms to oversee delegated Member Services functions.

Element A: Delegation Agreement

The written delegation agreement:

1. **Is mutually agreed upon.**
2. **Describes the delegated activities and the responsibilities of the organization and the delegated entity and the delegated activities.**
3. **Requires at least semiannual reporting by the delegated entity to the organization.**
4. **Describes the process by which the organization evaluates the delegated entity's performance.**
5. **Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.**

Summary of Changes

- This element was formerly RR 5, Element A.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 5 factors~~	~~The organization meets 4 factors~~	~~The organization meets 3 factors~~	~~The organization meets 2 factors~~	~~The organization meets 0-1 factors~~

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

Data source Materials

Scope of review NCQA reviews delegation agreements in effect during the look-back period from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

The score for the element is the average of the scores for all delegates.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 24 months.

Explanation This element may not be delegated.

This element applies to agreements in effect within the look-back period.

The delegation agreement describes all delegated RR activities. A generic policy statement about the content of delegated arrangements does not meet this element.

Factor 1: **Mutual agreement**

Delegation activities are mutually agreed on or before delegation begins, in a dated, binding document or communication between the organization and the delegated entity.

NCQA considers the effective date specified in the delegation agreement as the mutually agreed-upon effective date. The effective date may be before or after the signature date on the agreement. If the agreement has no effective date, NCQA considers the signature date (the date of the last signature) as the mutually agreed upon effective date.

NCQA may accept other evidence of the mutually agreed-upon effective date: a letter, meeting minutes or other form of communication between the organization and the delegate that references the parties' agreement on the effective date of delegated activities.

NCQA requires submitted evidence for all other delegation factors to consider the same mutually agreed-upon date as the effective date for the delegate's performance of delegated activities.

Factor 2: **Assigning responsibilities**

The delegation agreement or an addendum thereto or other binding communication between the organization and the delegate specifies the RR activities:

- Performed by the delegate.
- Not delegated, but retained by the organization.
  - The organization may include a general statement in the agreement addressing the retained functions (e.g., the organization retains all other ME functions not specified in this agreement as the delegate's responsibility).

If the delegate subdelegates an activity, the delegation agreement must specify which organization is responsible for oversight of the subdelegate.

Factor 3: **Reporting**

The organization determines the method of reporting and the content of the reports, but the agreement must specify:

- That reporting is at least semiannual.
- What information is reported by the delegate about delegated activities.
- How, and to whom, information is reported (i.e., joint meetings or to appropriate committees or individuals in the organization).

The organization must receive regular reports from all delegates, including NCQA-Accredited or NCQA-Certified delegates.

Factor 4: **Performance monitoring**

The delegation agreement states the organization's process for monitoring and evaluating the delegate's performance.

Factor 5: **Consequences for failure to perform**

The delegation agreement specifies consequences if a delegate fails to meet the terms of the agreement and, at a minimum, circumstances that would cause revocation of the agreement.

Exception

This element is NA if the organization does not delegate ~~RR~~ ME activities.

Examples None.

Element B: Predelegation Evaluation

For new delegation agreements initiated in the look-back period, the organization evaluates delegate capacity to meet NCQA requirements before delegation began.

Summary of Changes

- This element was formerly RR 5, Element B.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization evaluated delegate capacity before delegation began~~	~~No scoring option~~	~~The organization evaluated delegate capacity after delegation began~~	~~No scoring option~~	~~The organization did not evaluate delegate capacity~~

Met	Partially Met	Not Met
The organization evaluated delegate capacity before delegation began	The organization evaluated delegate capacity after delegation began	The organization did not evaluate delegate capacity

Data source Reports

Scope of review

This element applies if delegation was implemented in the look-back period.

NCQA reviews the organization's predelegation evaluation for up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

The score for the element is the average of the scores for all delegates.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

This element may not be delegated.

NCQA-Accredited/Certified delegates

Automatic credit is available for this element if all delegates are NCQA-Accredited health plans or MBHOs, or are NCQA Certified in Health Information Products, unless the element is NA. NCQA-Certified Health Information Product organizations must be certified to perform the activity being delegated by the organization.

Note: *For organizations that have both NCQA-Accredited/Certified and non-Accredited/Certified delegates:*

- *NCQA-Accredited/Certified delegates are eligible for automatic credit.*
- *Non-Accredited/Certified delegates are reviewed and scored accordingly.*

Predelegation evaluation

The organization evaluated the delegate's capacity to meet NCQA requirements within 12 months prior to implementing delegation. The evaluation may include a review of the delegate's structure, processes and staffing in order to determine its capability to perform the delegated function.

NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date.

If the time between the predelegation evaluation and implementation of delegation exceeds the 12 months, the organization conducts another predelegation evaluation.

If the organization amends the delegation agreement to include additional RR activities within the look-back period, it performs a predelegation evaluation for the additional activities.

Exceptions

This element is NA if:

- The organization does not delegate RR activities.
- Delegation arrangements have been in effect for longer than the look-back period.

Examples

Predelegation evaluation

- Site visit.
- Telephone consultation.
- Documentation review.
- Committee meetings.
- Virtual review.

Element C: Review of Performance

For delegation arrangements in effect for 12 months or longer, the organization:

1. **Semiannually evaluates regular reports, as specified in Element A.**
2. **Annually evaluates delegate performance against NCQA standards for delegated activities.**

Summary of Changes

- This element was formerly RR 5, Element C.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 2 factors~~	~~No scoring option~~	~~The organization meets 1 factor~~	~~No scoring option~~	~~The organization meets 0 factors~~

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

Data source

Reports

Scope of review

NCQA reviews evidence of the organization's review from up to four randomly selected delegates, or all delegates if the organization has fewer than four.

For Initial Surveys: NCQA reviews the organization's most recent performance evaluation and semiannual report evaluation completed during the look-back period.

For Renewal Surveys: NCQA reviews the most recent and previous year's performance evaluations and four semiannual report evaluations completed during the look-back period.

The score for the element is the average of the scores for all delegates.

Look-back period

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

For Renewal Surveys: 24 months.

Explanation

This element may not be delegated.

NCQA-Accredited/Certified delegates

Automatic credit is available for factor 2 if all delegates are NCQA-Accredited health plans or MBHOs, or are NCQA Certified in Health Information Products, unless the element is NA. NCQA-Certified Health Information Product organizations must be certified to perform the activity being delegated by the organization.

Note: *For organizations that have both NCQA-Accredited/Certified and non-*

Accredited/Certified delegates:

- *NCQA-Accredited/Certified delegates are eligible for automatic credit.*
- *Non-Accredited/Certified delegates are reviewed and scored accordingly.*

Factor 1: **Evaluation of reports**

No additional explanation required.

Factor 2: **Annual evaluation**

Annual evaluation is based on the delegation agreement and the appropriate NCQA standards and includes a review of the delegate's policies and procedures.

Exceptions

The element is NA if:

- The organization does not delegate RR activities.
- Delegation arrangements have been in effect for less than 12 months.

Examples

Factor 2: Annual evaluation

- Site visit.
- Telephone consultation.
- Documentation review.
- Committee meetings.
- Virtual review.

Element D: Opportunities for Improvement

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identified and followed up on opportunities for improvement, if applicable.

Summary of Changes

- This element was formerly RR 5, Element D.
- Adjusted scoring to "Met," "Partially Met" and "Not Met."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~At least once in each of the past 2 years the delegation arrangement has been in effect, the organization acted on identified problems, if any~~	~~No scoring option~~	~~The organization took inappropriate or weak action, or has taken action only in the past year~~	~~No scoring option~~	~~The organization has taken no action on identified problems~~

Met	Partially Met	Not Met

At least once in each of the past 2 years the delegation arrangement has been in effect, the organization acted on identified problems, if any	The organization took inappropriate or weak action, or has taken action only in the past year	The organization has identified no action on the identified problems

Data source Documented process, Reports, Materials

Scope of review NCQA reviews reports for opportunities for improvement from up to four randomly selected delegates, or from all delegates, if the organization has fewer than four, and for evidence that the organization took appropriate action to resolve issues.

For Initial Surveys: NCQA reviews the organization's most recent annual review and follow-up on improvement opportunities.

For Renewal Surveys: NCQA reviews the organization's most recent and previous year's annual reviews and follow-up on improvement opportunities.

The score for the element is the average of the scores for all delegates.

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

For Renewal Surveys: 24 months.

Explanation This element may not be delegated.

NCQA-Accredited/Certified delegates

Automatic credit is available for this element if all delegates are NCQA-Accredited health plans or MBHOs, or are NCQA Certified in Health Information Products, unless the element is NA. NCQA-Certified Health Information Product organizations must be certified to perform the activity being delegated by the organization.

Note: *For organizations that have both NCQA-Accredited/Certified and non-Accredited/Certified delegates:*

- *NCQA-Accredited/Certified delegates are eligible for automatic credit.*
- *Non-Accredited/Certified delegates are reviewed and scored accordingly.*

Identify and follow up on opportunities

The organization uses information from its predelegation evaluation, ongoing reports or annual evaluation to identify areas of improvement.

Exceptions

This element is NA if:

- The organization does not delegate RR activities.
- Delegation arrangements have been in effect for less than 12 months.
- The organization has no opportunities to improve performance.

NCQA evaluates whether this conclusion is reasonable, given assessment results.

Examples None.