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# QI 3: Continuity and Coordination of Care

**The organization demonstrates continuity and coordination of care across the health care network and between medical and behavioral healthcare.**

## Intent

**The organization demonstrates continuity and coordination of medical and behavioral healthcare across its delivery system.**

## Element E: Transition to Other Care

**The organization helps with members' transition to other care when their benefit ends, if necessary.**

## Summary of Changes

- Retire this element for all survey types.

**Scoring**

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

**Data source**

Documented process, Reports, Materials, Records or files

**Scope of review**

**Product lines**

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

**Documentation**

NCQA reviews a documented process and three examples (reports, materials, records or files) of how the organization helped members transition to other care, 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 First Surveys:* 6 months.

*For Renewal Surveys:* 24 months.

**Explanation**

**Exhausted benefits**

This element applies to any covered benefits that are exhausted when a member continues to need care and is still a member of the organization. Individuals who are no longer members of the health plan (e.g., member no longer meet Medicaid eligibility requirements) are not in the scope of this element.

If the organization's covered benefits are exhausted while a member needs care, the organization notifies the member about alternatives for continuing care, and how to

obtain care, as appropriate.

The organization is not required to develop alternatives for continuing care.

**Exceptions**

This element is NA for Interim Surveys.

**Related information**

*No evidence of exhausted benefits during the look-back period.* If during the look-back period, the organization does not have evidence that members required assistance in transitioning care when their benefits were exhausted, NCQA reviews the organization's policies and procedures and documentation (e.g., attestation, reports, materials) indicating that there were no instances during the look-back period.

*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.

*No benefit limitations.* If the organization has no benefit limitations (i.e., benefits may never be exhausted), NCQA reviews the organization's policies and procedures indicating that there are no 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.

# PHM 5: Complex Case Management

**The organization coordinates services for its highest risk 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: 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

- Removed Renewal Surveys from the scope of review and look-back period; made Renewal Surveys an exception.

**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**

*For Interim Surveys and First Surveys: ~~and Renewal Surveys:~~ This element applies to all product lines.*

**Documentation**

NCQA reviews the organization's policies and procedures.

*For First Surveys ~~and Renewal Surveys~~:* 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 Interim Surveys:* Prior to the survey date.

*For First 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 to 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 other organization's program.

**Identification** is how members are segmented or stratified into the complex case management program using the process described in *PHM 2: Population Identification,* Element D. Members are considered "identified" on the date when they are assigned to a segment or stratum.

In addition, to the process described in PHM 2, Element D, multiple referral avenues can minimize the time between identifying a need and delivering services.

The organization has a process for facilitating referrals listed in the factors, even if it does not currently have access to the referral source. NCQA reviews communication of referral options to members and practitioners.

***Factor 1:*** **Medical management program referral**

Medical management program referrals include those that come from other organization programs 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.

***Factors 3, 4:*** **Member, caregiver and practitioner referral**

The organization communicates referral options to members (factor 3) and practitioners (factor 4).

**Exceptions**

~~None.~~ This element is NA for Renewal Surveys.

**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 C: Case Management Process

**The organization's complex case management procedures address the following:**

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. **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 community resources.**
12. **Development of an individualized case management plan, including prioritized goals and considers member and caregiver goals, preferences and desired level of involvement in the case management plan.**
13. **Identification of barriers to the member meeting goals or complying with the case management 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 a member self-management plan.**
17. **A process to assess member progress against the case management plan.**

## Summary of Changes

- Removed the requirement that each factor must have a conclusion.

**Scoring**

| 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**

**Product lines**

*For Interim Surveys and First Surveys: This element applies to all product lines.*

**Documentation**

NCQA reviews the organization's policies and procedures in place throughout the look-back period.

**Look-back period**

*For Interim Surveys:* Prior to the survey date.

*For First Surveys:* 6 months.

**Explanation**

This 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. Organizations determine the qualifications (including licensure and certification) necessary to perform complex case management functions, based on industry standards or regulatory requirements.~~

~~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, 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.~~

Assessment involves more than collecting data or completing checklists. It must capture information most relevant to developing and managing the case management plan, and requires the case manager or other qualified individual to interpret and document information about the member.

The case record includes a documented overall conclusion assessment summary that brings together the information collected throughout the assessment and explains how the information informs understanding of the member's overall needs and priorities for care planning.

The organization must draw an overall conclusion from the assessment, but is not required to draw a conclusion for each factor. The file should document any conclusion relevant to the member's care (e.g., "the patient does not understand English"). The overall conclusion of the assessment may be a single narrative or in a format with multiple conclusions.

If the organization's case management system automatically generates prompts, recommendations or suggested content, the case manager or other individual must still document their overall assessment of the member's responses based on their professional judgment. Automated output or raw responses alone do not meet the intent without an overall assessment conclusion that reflects the case manager's interpretation of the information collected.

Case management policies and procedures describe circumstances when assessment of a specific factor may not be appropriate (e.g., life-planning activities or pediatric cases). In these instances, the organization documents the factor and the reason it was not assessed in the case management system or file.

The organization determines the qualifications (including licensure and certification) necessary to perform complex case management functions, based on industry standards or regulatory requirements.

### *Factor 1:* Initial assessment of member's 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., high-risk pregnancy and heart disease, for members with diabetes). The assessment includes:

- 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 necessary for accurate documentation of the member's clinical history. To the extent possible, the organization collects dates as part of documenting clinical history. NCQA does not penalize an organization if a member or 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 related 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,[2] 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.

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

### *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. Assessment includes determining whether the resources available to the member are adequate for 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. Resources must include:

- Community mental health.
- Transportation.
- Wellness organizations.
- 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 frames for reevaluation of goals.
  - Time frames 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 between settings.
- 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 performed a barrier analysis, even if no barriers 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 referral to a disease management program or health resource). The complex case management plan contains a schedule for follow-up that includes, but is not limited to:

- Counseling.
- Follow-up after referral to a DM 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 for Renewal Surveys.

**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 (cuing, repetition, reminders) only under stressful situations or unfamiliar conditions.
- Requires assistance and some direction in specific situations (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 13:*** **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 D: 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 (ADL).**
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

- Removed the requirement that each factor must have a conclusion.

**Scoring**

| 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**

**Product lines**

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

**Documentation**

NCQA reviews initial assessments in a random sample of up to 40 complex case management files. Files are selected from active or closed member 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 First Surveys:* 6 months.

*For Renewal Surveys:* 12 months.

**Explanation**

Initial assessment files are reviewed on the requirements in Element C.

Documentation to meet the factors includes evidence that the assessment components were completed, and documented results of each assessment. A checklist of assessment components that does not document results does not meet the requirement.

Assessment may be completed by members of the care team, with assistance from 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.

**Assessment and evaluation**

~~Assessment and evaluation require the case manager or other qualified individual to draw and document a conclusion about data or information collected. Organizations determine the qualifications (including licensure and certification) necessary to perform complex case management functions, based on industry standards or regulatory requirements.~~

~~If the organization's case management system automatically generates suggestions, the case manager or other individual must still document their own conclusions; raw data or answers to questions is not sufficient. There is a documented summary of the meaning or implications of the information to the member's situation, addressing whether benefits and resources are appropriate and sufficient, for use in the case management plan. The automated case management system must document the dates associated with entries for factors 1–12.~~

~~The organization must draw a conclusion for each factor (unless otherwise stated in the explanation). This may be in separate summaries for each factor, in a combined summary or in a combination of these.~~

Assessment involves more than collecting data or completing checklists. It must capture information most relevant to developing and managing the case management plan, and requires the case manager or other qualified individual to interpret and document information about the member.

The case record includes a documented overall conclusion that brings together the information collected throughout the assessment and explains how the information informs understanding of the member's overall needs and priorities for care planning.

The organization must draw an overall conclusion from the assessment, but is not required to draw a conclusion for each factor. The file should document any conclusion relevant to the member's care (e.g., "the patient does not understand English"). The overall conclusion of the assessment may be a single narrative or in a format with multiple conclusions.

If the organization's case management system automatically generates prompts, recommendations or suggested content, the case manager or other individual must still document their overall assessment of the member's responses based on their professional judgment. Automated output or raw responses alone do not meet the intent without an overall assessment conclusion that reflects the case manager's interpretation of the information collected.

Case management policies and procedures describe circumstances when assessment of a specific factor may not be appropriate (e.g., life-planning activities or pediatric cases). In these instances, the organization documents the factor and the reason it was not assessed in the case management system or file.

The organization determines the qualifications (including licensure and certification) necessary to perform complex case management functions, based on industry standards or regulatory requirements.

***Note:*** *"Identification" is the point where a member is segmented or stratified into the complex case management program using the process described in PHM 2, Element D.*

**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 one of 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 the 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 dosages and schedule.

***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.
- Past medications.

Dates are 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.

For activities with which the member needs assistance, the case manager documents the reason and type of assistance. The case manager is not required to describe activities for which the member does not need assistance.

If the member needs no assistance with any ADLs, the case file or case notes reflect this (e.g., "Member is fully independent with ADLs").

***Factor 4:*** **Initial assessment of behavioral health status**

The file or case record documents the 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 the 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 the 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 the 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 the 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 case notes reflect this (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 the 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 life planning activities are determined not to be appropriate, the case manager documents the reason in the case management record or file.

As an alternative to an assessment of life planning needs, the organization may provide life planning information (e.g., brochure, pamphlet) to members in complex case management during the time frame allowed for completing the initial assessment. The file must document that the information was provided and the date.

***Factor 12:*** **Beginning the assessment within 30 calendar days of identification**

The organization begins the 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. The organization must complete at least one factor within 30 calendar days of identification to meet this requirement. 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 its actions 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 for Interim Surveys.

**Examples** None.

# NET 4: Continued Access to Care

**The organization monitors and takes action, as necessary, to improve continuity and coordination of care across the health care network.**

## Intent

**The organization uses information at its disposal to facilitate continuity and coordination of medical care across its delivery system.**

## Element A: Notification of Termination

**The organization notifies members affected by the termination of a practitioner or practice group in general, family or internal medicine or pediatrics, at least 30 calendar days prior to the effective termination date, and helps them select a new practitioner.**

## Summary of Changes

- Removed Renewal Surveys from the scope of review and look-back period; made Renewal Surveys an exception.

**Scoring**

| Met | Partially Met | Not Met |
|---|---|---|
| The organization notifies members at least 30 calendar days prior to the effective date of termination | No scoring option | The organization does not notify members at least 30 calendar days prior to the effective date of termination |

**Data source** Documented process, Reports, Materials

**Scope of review**

**Product lines**

*For First Surveys ~~and Renewal Surveys~~: This element applies to all product lines.*

**Documentation**

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 First Surveys:* 6 months.

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

**Explanation** Even if there were no terminations, the organization must have policies and procedures for notifying members of practitioner 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.

**Explanation**

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 online. The organization mails the notification to members who do not have fax, email or internet access.

**Exception**

This element is NA for Interim Surveys and Renewal Surveys.

**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 define 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

**If a practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner, as follows:**

1. **Continuation of treatment through the current period of active treatment, or for up to 90 calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition.**
2. **Continuation of care through the postpartum period for members in their second or third trimester of pregnancy.**

## Summary of Changes

- Removed Renewal Surveys from the scope of review and look-back period; made Renewal Surveys an exception.

**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, Records or files

**Scope of review**

**Product lines**

*For First Surveys ~~and Renewal Surveys~~: This element applies to all product lines.*

**Documentation**

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 met 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 First Surveys:* 6 months.

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

**Explanation** All practitioner specialties are included in factor 1.

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 allowing members to have access to care and treatment.

The organization works with practitioners who are no longer under contract to develop a reasonable transition plan for each member in active treatment or postpartum period.

In an **active course of treatment,** 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 asthma, not for an acute phase of the condition).

The postpartum period begins immediately after childbirth and extends for approximately 6 weeks.

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**

This element is NA for Interim Surveys and Renewal Surveys.

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 factors 1 and 2.

# NET 5: Physician and Hospital Directories

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

## Intent

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

## Element G: Usability Testing

~~**The organization evaluates its web-based physician and hospital directories for understandability and usefulness to members and prospective members at least every 3 years, and considers the following:**~~

1. ~~**Reading level.**~~
2. ~~**Intuitive content organization.**~~
3. ~~**Ease of navigation.**~~
4. ~~**Directories in additional languages, if applicable to the membership.**~~

## ~~Summary of Changes~~

- Retire this element for all survey types.

**~~Scoring~~**

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

**~~Data source~~** ~~Documented process, Reports~~

**~~Scope of review~~**

~~**Product lines**~~

~~*For First Surveys and Renewal Surveys: This element applies to all product lines.*~~

~~**Documentation**~~

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

**~~Look-back period~~** ~~*For First Surveys and Renewal Surveys:* At least once in the prior 36 months.~~

**~~Explanation~~**

~~The organization conducts usability testing:~~

- ~~When there are significant changes to member demographics.~~

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

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

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

***Factors 1–4:*** **Usability testing**

No additional explanation required.

**Exceptions**

This element is NA for Interim Surveys.

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

**Related information**

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

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

**Examples**

None.

## Element H: Availability of Directories

**~~The organization makes web-based physician and hospital directory information available to members and prospective members through alternative media, including:~~**

1. **~~Print.~~**
2. **~~Telephone.~~**

## ~~Summary of Changes~~

- Retire this element for all survey types.

**~~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, Materials~~

**~~Scope of review~~**

**~~Product lines~~**

~~*For First Surveys and Renewal Surveys: This element applies to all product lines.*~~

**~~Documentation~~**

~~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 First 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 physician and hospital directories.~~

**~~Exception~~**

~~This element is NA for Interim Surveys.~~

**~~Examples~~**

~~None.~~

# CR 2: Credentialing Committee

**The organization designates a Credentialing Committee that uses a peer-review process to make recommendations regarding credentialing decisions.**

## Intent

**The organization obtains meaningful advice and expertise from participating practitioners when it makes credentialing decisions.**

## Element A: Credentialing Committee

**The organization's Credentialing Committee:**

1. **Uses participating practitioners to provide advice and expertise for credentialing decisions.**
2. **Reviews credentials for practitioners who do not meet established thresholds.**
3. **Ensures that files that meet established criteria are reviewed and approved by a medical director, designated physician or the Credentialing Committee.**

## Summary of Changes

- Removed reports as a data source, updated the scope of review and explanation indicating that NCQA only reviews the credentialing committee charter.

**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, Reports

**Scope of review**

**Product lines**

*For Interim Surveys, First Surveys and Renewal Surveys: This element applies to all product lines.*

**Documentation**

*For All Surveys:* NCQA reviews the credentialing committee charter.

~~*For Interim Surveys:* NCQA reviews Credentialing Committee minutes from three different meetings. If three meeting minutes are not available for review, NCQA reviews the minutes from the look-back period. If the committee has not met, NCQA reviews the committee charter, and reviews a timeline for operationalizing the committee.~~

~~*For First Surveys and Renewal Surveys:* NCQA reviews Credentialing Committee meeting minutes from three different meetings within the look-back period. If the required meeting minutes are not available for review, NCQA reviews the minutes from the look-back period.~~

**Look-back period**

*For Interim Surveys:* Prior to the survey date.

*For First Surveys:* 6 months.

*For Renewal Surveys:* 24 months.

**Explanation**

***Factor 1:* Participating practitioners**

The Credentialing Committee is a peer-review body with members from the types of practitioners participating in the organization's network.

The organization may have separate review bodies for each practitioner type (e.g., physician, oral surgeon, psychologist), specialty or multidisciplinary committee, with representation from various specialties.

If the organization is part of a regional or national organization, a regional or national Credentialing Committee that meets the criterion may serve as the peer review committee for the local organization.

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

***Factor 2:*** Scope of **Committee review**

The Credentialing Committee:

- Reviews the credentials of practitioners who do not meet the organization's criteria for participation in the network.
- Reviews and provides ~~Gives~~ thoughtful consideration to credentialing information.
- Documents discussions about credentialing in meeting minutes.

Meetings and decisions may take place in real-time, virtual meetings (i.e., through video conference or web conference with audio), but may not be conducted only through email.

***Factor 3:* Review of files that meet established thresholds**

For files that meet the organization's credentialing criteria, the organization:

- Submits all practitioner files to the Credentialing Committee for review, ***or***
- Has a process for medical director or qualified physician review and approve clean files.
  - Evidence of review and approval is a handwritten signature, handwritten initials or unique electronic identifier, if the organization has appropriate controls for ensuring that only the designated medical director or qualified physician can enter the electronic signature.
  - An individual signature is not required in each practitioner file if there is one report with a signature that lists all required credentials for all practitioners with clean files.
  - Clean files that meet the organization's established criteria may be reviewed by email.

NCQA scores this factor "Yes" if the organization's charter indicates ~~presents~~ that all files (including clean files) to the Credentialing Committee.

**Exceptions**

None.

~~**Related information**~~

~~*Assessment of timeliness.* NCQA considers a practitioner to be credentialed as of the Credentialing Committee or date of the medical director's decision, and uses this date to assess timeliness in the file review elements, even if a review board or governing body reviews decisions made by the Credentialing Committee or medical director.~~

~~*Providing care to members.* The organization does not permit uncredentialed practitioners to provide care to members.~~

~~Some states require reimbursement of practitioners back to the date the application, for members seen during the credentialing process period, if the organization subsequently decides to credential the practitioner. Such retroactive payment is outside the scope of NCQA's credentialing requirement.~~

**Examples** None.

# CR 7: Assessment of Organizational Providers

**The organization has written policies and procedures for initial and ongoing assessment of providers with which it contracts.**

## Intent

**The organization evaluates the quality of providers with which it contracts.**

## Element A: Review and Approval of Provider

**The organization's policy for assessing a health care delivery provider specifies that before it contracts with a provider, and for at least every 36 months thereafter, it:**

1. **Confirms that the provider is in good standing with state and federal regulatory bodies.**
2. **Confirms that the provider has been reviewed and approved by an accrediting body.**
3. **Conducts an onsite quality assessment if the provider is not accredited.**

## Summary of Changes

- Added a note under the explanation of factor 3 to indicate a virtual review may be conducted in lieu of an onsite visit.

**Scoring**

| 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

**Scope of review**

**Product lines**

*For Interim Surveys and First Surveys: This element applies to all product lines.*

**Documentation**

NCQA reviews the organization's policies and procedures in place throughout the look-back period.

**Look-back period**

*For Interim Surveys:* Prior to the survey date.

*For First Surveys:* 6 months.

**Explanation**

An **organizational provider** is a facility that provides services to members, and where members are directed for services rather than to a specific practitioner. This element applies to all organizational providers with which the organization contracts (e.g., telemedicine providers, urgent care centers, durable medical equipment suppliers). Facilities that do not provide services directly to members (e.g., durable medical equipment organizations that provide supplies to a practitioner's office) are not in the scope of review.

### *Factor 1:* Confirmation with state and federal regulatory bodies

The organization's policies and procedures specify sources used to confirm that providers are in good standing with state and federal requirements, including:

- Applicable state or federal agency.
- Agent of the applicable state or federal agency.
- Copies of credentials (e.g., state licensure) from the provider.

NCQA does not accept an attestation from a provider to the organization about the provider's regulatory status.

### *Factor 2:* Confirmation of review and approval by an accrediting body

The organization's policies and procedures specify sources used to confirm the provider's accreditation status, including:

- Applicable accrediting body for each type of organizational provider.
- Agent of the applicable accrediting body.
- Copies of credentials (e.g., accreditation report, certificate or decision letter) from the provider.

NCQA does not accept an attestation from a provider to the organization about the provider's accreditation status.

### *Factor 3:* Site visits for unaccredited facilities

The organization's policies and procedures include:

- Onsite quality assessment criteria for each type of provider.
- A process ensuring that the providers credential their practitioners.

The organization receives credit for this factor if its policies and procedures specify that it contracts only with accredited providers.

If a provider has satellite facilities that follow the same policies and procedures as the provider, the organization may limit site visits to a main facility.

***Note:*** *A virtual review may be conducted in lieu of an onsite visit. Organizations must still evaluate provider quality using sufficient evidence. Organizations may determine how to conduct the virtual review.*

#### State or federal review in lieu of a site visit

The organization may have a policy to substitute a CMS or state quality review in lieu of a site visit under the following circumstances:

- The CMS or state review is no more than 3 years old.
  - If the CMS or state review is older than 3 years, the organization conducts its own onsite quality review.
- The organization obtains a survey report or letter from CMS or the state, from either the provider or the agency, stating that the facility was reviewed and passed inspection.

– The report meets the organization's quality assessment criteria or standards.

The organization is not required to conduct a site visit if the provider is in a rural area, as defined by the U.S. Census Bureau (https://www.hrsa.gov/rural-health/about-us/definition/datafiles.html), and the state or CMS has not conducted a site review.

**Exception**

This element is NA for Renewal Surveys.

**Related information**

*Time frame.* NCQA does not prescribe a time frame for gathering data to use for assessing organizational providers (e.g., the 120-calendar-day rule, applied against the verification of credentials of individual practitioners, is NA).

**Examples** None.

## Element D: Assessing Medical Providers

**The organization assesses contracted medical health care providers against the requirements and within the time frame in Element A.**

## Summary of Changes

- Added a second paragraph under the explanation to indicate that a virtual review may be conducted in lieu of an onsite visit.

**Scoring**

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

**Data source** Reports, Records or files

**Scope of review**

**Product lines**

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

**Documentation**

NCQA reviews evidence that the organization assessed the providers in Element B. The organization provides documentation of a tracking mechanism(s) (checklist or spreadsheet); a separate tracking mechanism or report is not required for each provider.

**Look-back period**

*For First Surveys:* 6 months.

*For Renewal Surveys:* 24 months.

**Explanation** The organization is not required to conduct a site visit if the provider is in a rural area, as defined by the U.S. Census Bureau (https://www.hrsa.gov/rural-health/about-us/definition/datafiles.html), and the state or CMS has not conducted a site review.

If a site visit is required, a virtual review may be conducted in lieu of an onsite visit. Organizations must still evaluate provider quality using sufficient evidence. Organizations may determine how to conduct the virtual review.

**Exception**

This element is NA for Interim Surveys.

**Examples**

***Table 1: Assessment of organizational providers tracking log***

| Organization Name | Organization Type | Confirmation Dates and Statuses | | |
|---|---|---|---|---|
| | | **Licensing & Regulatory** | **Accrediting Body** | **Site Visit** |
| Mega | Hospital | 4/1/2023; Active | 4/10/2023; Name; Active | Rural provider, visit not conducted by state or CMS. |
| | | 4/5/2026; Active | 4/15/2026; Name; Active | Rural provider, visit not conducted by state or CMS. |
| Downtown Surgery Center | Free-Standing Surgical Center | 3/2/2023 Active | None | 2/10/2023; CMS Compliant |
| | | 3/15/2026; Active | None | 2/2/2026; CMS Compliant |
| District Physicians | Home Health | 3/2/2023; Active | 3/20/2023; Name; Active | Rural provider, visit not conducted by state or CMS. |
| | | 3/17/2026; Active | 3/20/2026; Name; Active | Rural provider, visit not conducted by the state or CMS. |

## Element E: Assessing Behavioral Healthcare Providers

**The organization assesses contracted behavioral healthcare providers against the requirements and within the time frame in Element A.**

## Summary of Changes

- Added a third paragraph under the explanation to indicate that a virtual review may be conducted in lieu of an onsite visit.

**Scoring**

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

**Data source** Reports, Records or files

**Scope of review**

**Product lines**

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

**Documentation**

NCQA reviews evidence that the organization assessed the providers in Element C. The organization provides documentation of a tracking mechanism(s) (checklist or spreadsheet); a separate tracking mechanism or report is not required for each provider.

**Look-back period**

*For First Surveys:* 6 months.

*For Renewal Surveys:* 24 months.

**Explanation**

The organization is not required to conduct a site visit if the provider is in a rural area, as defined by the U.S. Census Bureau (https://www.hrsa.gov/rural-health/about-us/definition/datafiles.html), and the state or CMS has not conducted a site review.

The organization is also not required to conduct a site visit of ambulatory facilities that are not part of the organization's benefits package or are not available in the service area.

If a site visit is required, a virtual review may be conducted in lieu of an onsite visit. Organizations must still evaluate provider quality using sufficient evidence. Organizations may determine how to conduct the virtual review.

**Exceptions**

This element is NA:

- If all purchasers of the organization's services carve out or exclude behavioral healthcare.
- For Interim Surveys.

The organization provides evidence to support the score of "NA."

**Examples**

***Table 1: Assessment of behavioral healthcare organizational providers tracking log***

| Organization Name | Organization Type | Confirmation Dates and Statuses | | |
|---|---|---|---|---|
| | | Licensing & Regulatory | Accrediting Body | Site Visit |
| Mega X | Ambulatory | 4/1/2023; Active | 4/10/2023; Name; Active | NA |
| | | 4/5/2026; Active | 4/15/2026; Name; Active | NA |
| Getting Better | Residential | 3/2/2023; Active | None | 2/2/2023; CMS Compliant |
| | | 3/15/2026; Active | None | 2/10/2026; CMS Compliant |

# UM 1: Program Structure

**The organization's UM program has a clearly defined structure, 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 fairly, impartially and consistently.**

## Element A: Program Description

**The organization's written UM program description specifies:**

1. **The UM program structure.**
2. **The behavioral healthcare aspects of the UM program, if applicable.**
3. **The involvement of a designated senior-level physician in program implementation.**
4. **The involvement of a designated behavioral healthcare practitioner in program implementation, if applicable.**
5. **The oversight of the UM program by a UM Committee.**
6. **The process for determining which items and services require prior authorization.**
7. **The process for determining benefit coverage and medical necessity.**
8. **The information sources used to determine benefit coverage and medical necessity.**
9. The transparency of AI-generated outputs.

## Summary of Changes

- Added a new factor 9, adjusted scoring and updated the look-back period.

**Scoring**

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

**Data source** Documented process, Reports

**Scope of review**

**Product lines**

*For Interim Surveys and First Surveys: This element applies to all product lines.*

*For Renewal Surveys:*

- *Factors 1–4, 7 and 8 apply to the Medicaid product line only.*
- *Factors 5, 6 and 9 apply to all product lines.*

**Documentation**

*For Interim Surveys:* NCQA reviews the organization's UM program description.

*For First Surveys and Renewal Surveys:* NCQA reviews the organization's UM program description.

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

**Look-back period**

*For Interim Surveys:* Prior to the survey date.

*For First Surveys:* 6 months, prior to survey date for factor 9.

*For Renewal Surveys:* 24 months, 6 months for factors 5–6, prior to survey date for factor 9.

**Explanation**

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

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

**Medical necessity review**

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

Medical necessity applies to:

- Covered medical benefits defined by the organization's Certificate of Coverage or Summary of Benefits, including, but not limited to:
  - Dental and vision services covered under medical benefits, including dental care or services associated with procedures that occur within or adjacent to the oral cavity or sinuses.
    - If medical and dental benefits are not differentiated in the benefits plan, the organization includes requests for care or services associated with dental procedures that occur within or adjacent to the oral cavity or sinuses for medical necessity review.
  - Pharmaceuticals covered under medical or pharmacy benefits.

Decisions about the following require medical necessity review:

- Preexisting conditions, when the organization has a policy to deny coverage for care or services related to preexisting conditions.
- Care, items or services whose coverage depends on specific circumstances.
- Out-of-network services that are only covered in clinically appropriate situations.
- Prior authorizations for pharmaceuticals and pharmaceutical requests requiring a prerequisite drug for a step therapy program.

- "Experimental" or "investigational" requests covered by the organization.

Medical necessity review requires denial decisions to be made only by an appropriate clinical professional as specified in NCQA standards.

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, items 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 (ADL).
- "Experimental" or "investigational" care, items or services that are always excluded and are never covered under any circumstances. In these instances, the organization either:
  - Identifies the specific service or procedure excluded from the benefits plan, ***or***
  - If benefits plan materials include broad statements about exclusions but do not specify excluded services or procedures, the materials state that members have the opportunity to request information on excluded services or procedures and the organization maintains internal policies or criteria for these services or procedures.

UM denial decisions that do not require medical necessity review, and are subsequently appealed, 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.

### Denial file review universe

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.

The UM denial file review universe is separated into three categories:

1. *Nonbehavioral care.* Includes denials of requests for coverage of medical, dental, vision or other nonbehavioral care and nonpharmaceutical services, including, but not limited to, medical devices.
2. *Behavioral healthcare.* Includes denials of requests for evaluation or treatment of mental health conditions and psychological and substance abuse disorders.
3. *Pharmacy.* Includes denials of requests for pharmaceuticals covered under medical or pharmacy benefits, and administered or dispensed in all settings (e.g., inpatient, outpatient, at the pharmacy, at home). It does not include:
   - Denials of requests for medical devices (e.g., insulin pumps and other types of durable medical equipment).
   - Denials of requests for formulary exceptions (refer to UM 10: Procedures for Pharmaceutical Management, Element E).

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

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) as an appeal, such an approval does not fall under the scope of NCQA's appeal standards. The case is considered a denial if a denial notice was issued.

### Appeal file-review universe

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, quality-of-care or service issue). NCQA evaluates upheld appeals of an adverse decision for coverage of care or services under UM 9.

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

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

### *Factor 1:* Description of program structure

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

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

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

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

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

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

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

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

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

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

### *Factor 5:* Committee oversight of UM program

The committee overseeing the UM program may be either the organization's UM or QI Committee. The committee includes participation of a senior-level physician (factor 3) and a designated behavioral healthcare practitioner (factor 4), as applicable.

The organization describes the committee's oversight of the UM program. The committee oversees the UM functions, and annually:

- Evaluates the UM program structure, scope, processes and information sources used to determine benefit coverage and medical necessity.
- Reviews UM rates (Elements B–E).
- Identifies needed actions based on the evaluation.

***Note:*** *The organization may have another committee, such as a Pharmaceutical and Therapeutics Committee, review specific rates for Element G (e.g., P&T committee reviews pharmaceutical rates).*

### *Factor 6:* Process for determining items and services that require prior authorization

The program description describes the organization's decision-making process and criteria for determining items and services that require prior authorization and when prior authorization is no longer required.

### *Factors 7, 8:* Processes and information sources used to make determinations

The program description specifies:

- The organization's UM functions, the services covered by each function or protocol and the criteria used to determine medical necessity, including:
  - How the organization develops and selects criteria.
  - How the organization reviews, updates and modifies criteria.
- How medical necessity and benefits coverage for inpatient and outpatient services are determined.
- The description of the data and information the organization uses to make determinations (e.g., patient records, conversations with appropriate physicians) and guide the UM decision-making process.

  - The description should not be burdensome for the member, the practitioner or the health delivery organization's staff.
- The triage and referral process for behavioral healthcare services (if applicable).
- How sites of service and levels of care are evaluated for behavioral healthcare services (if applicable).

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

***Factor 9:*** **Transparency of AI-generated outputs**

If the organization uses artificial intelligence (as defined by NCQA and excluding static or rule-based algorithms) to support summarization, recommendations, or determinations, the organization's UM program defines how it identifies the criteria, information sources and data inputs used by the AI; and has the ability to trace each AI-generated summarization, recommendation, or determination back to the specific criteria and inputs used to produce it.

**Exceptions**

Factors 1–4, 7 and 8 are NA for Renewal Surveys for the commercial, Medicare and Exchange product lines.

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

Factor 6 is NA for organizations that do not manage or establish prior authorization criteria.

**Related information**

*Use of UM software applications.* Organizations cannot use software applications and algorithms (e.g., artificial intelligence algorithms) to make medical necessity denial decisions or upheld medical necessity or benefit appeal decisions involving medical necessity without a physician or other appropriate practitioner review.

The organization may use software applications and algorithms to make medical necessity approval decisions or recommendations, if the applications and algorithms use criteria based on sound clinical evidence.

*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.

*File review exclusions:* The following are excluded from the UM file review:

- Notice of Medicare Non-Coverage (NOMNC).
- DNOD/Grijalva Fast-Track denial and appeal for the Medicare product line.

**Examples**

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

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

- Setting UM policies.
- Supervising program operations.
- Reviewing UM cases.
- Participating on the UM Committee.
- Evaluating the overall effectiveness of the UM program.

***Factor 4:* Behavioral healthcare practitioner involvement**

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

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

***Factor 6:* Criteria for determining items and services that require prior authorization**

1. *Medical necessity*
   - Determine whether the service is medically necessary based on evidence-based guidelines, clinical research or professional standards of care.
   - Validate the service aligns with the best outcomes for the patient.
2. *Utilization patterns*
   - Review the frequency and variability of use of the service.
     - Services with high variability in usage or potential overuse are more likely to require prior authorization.
   - Evaluate whether the service has a history of being used inappropriately or excessively.
   - Validate appropriate use to protect patient safety and reduce unnecessary health care costs.
3. *Cost-effectiveness*
   - Analyze the cost implications of the service, especially if it involves high-cost drugs, procedures or technologies.
4. *Complexity or specialized nature of services*
   - Identify services that are complex, experimental or require specialized training or facilities.

5. *Quality and outcomes*
   - Assess whether prior authorization can help ensure the delivery of high-quality care and prevent avoidable complications or adverse outcomes.
   - Validate that services provided are likely to yield measurable benefits.
6. *Alternative treatments*
   - Consider whether less invasive, less costly or equally effective alternatives are available and require that they are utilized first when clinically appropriate.
7. *Regulatory standards*
   - Adhere to guidelines established by regulatory bodies.
   - Align prior authorization practices with industry standards.
8. *Data and analytics*
   - Use data, patient outcomes, and other analytics to identify trends or areas where prior authorization may help manage care more effectively.
9. *Stakeholder input*
   - Incorporate feedback from health care providers, patients, and other stakeholders to ensure the policy is balanced and addresses real-world concerns.
10. *Duration and review frequency*
    - Establish a periodic review process to decide whether to retain or remove prior authorization based on changes in clinical evidence, utilization patterns or cost data.

# UM 2: Clinical Criteria for UM Decisions

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

## Intent

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

## Element A: UM Criteria

**The organization:**

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

## Summary of Changes

- Removed Renewal Surveys from the scope of review and look-back period; made Renewal Surveys an exception.

**Scoring**

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

**Data source** Documented process, Reports, Materials

**Scope of review**

**Product lines**

*For Interim Surveys and First Surveys ~~and Renewal Surveys~~: This element applies to all product lines.*

**Documentation**

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

*For First Surveys ~~and Renewal Surveys~~:* NCQA reviews:

- *For factors 1–3:* The organization's policies and procedures in place throughout the look-back period.

- *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:* Most recent annual review and update (for *First Surveys*) or most recent and previous year's annual reviews and updates (for *Renewal Surveys*).

**Look-back period**

*For Interim Surveys:* Prior to the survey date.

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

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

**Explanation**

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

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

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

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

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

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

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

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

***Factor 4:*** **Practitioner involvement**

Practitioners with clinical expertise in the area being reviewed are provided 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.

***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, or other designated group, may determine if further review of a criterion is necessary.

**Exceptions**

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

This element is NA for Renewal Surveys.

**Related information**

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

**Examples**

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

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

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

***Factor 4:*** **Practitioner involvement**

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

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

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

# 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 F: Use of Board-Certified Consultants

**The organization:**

1. **Has written procedures for using board-certified consultants to assist in making medical necessity determinations.**
2. **Provides evidence that it uses board-certified consultants for medical necessity determinations.***

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

## Summary of Changes

- Removed Renewal Surveys from the scope of review and look-back period; made Renewal Surveys an exception.

**Scoring**

| 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**

**Product lines**

*For Interim Surveys and First Surveys ~~and Renewal Surveys~~: This element applies to all product lines.*

**Documentation**

*For All Surveys:* For factor 1, NCQA reviews the organization's written policies and procedures for using internal and external board-certified consultants, and reviews the list of board-certified consultants.

*For First Surveys ~~and Renewal Surveys~~:* For factor 2, NCQA also reviews three cases showing the use of external board-certified 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 board-certified consultants, NCQA reviews three cases showing the use of internal consultants.

**Look-back period**

*For Interim Surveys:* Prior to the survey date.

*For First Surveys:* 6 months.

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

**Explanation**

Factor 2 is a critical factor; if it is scored "No," the element score cannot exceed Not Met.

This element applies to medical necessity determinations.

***Factor 1:* Policies and procedures for using board-certified consultants**

The organization has written policies and procedures for using internal and external board-certified consultants. The organization maintains a list of board-certified consultants that includes contact information (e.g., phone numbers, names, specialties, email), 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 board-certified consultants, for proprietary reasons, they may provide a list of the specialties of all board-certified 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 board-certified consultants**

NCQA reviews three cases showing the use of external board-certified consultants for medical necessity determinations. If the organization does not have three cases of using external board-certified 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**

Factor 2 is NA for Interim Surveys.

<u>This element is NA for Renewal Surveys.</u>

**Related information**

NCQA does not consider it delegation if a board-certified 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**

***Factors 1, 2:* Use of board-certified consultant**

An attending physician believes a newborn is suffering from a neurological disorder. The physician requests approval for the infant to be treated by a pediatric neurologist. The organization does not have a pediatric neurologist on staff, but it does have access to a board-certified pediatric neurologist through

a consulting firm. The organization collects the necessary clinical information and sends it to the consulting neurologist, who replies with a recommendation for authorization to an out-of-network pediatric neurologist within 24 hours.

# UM 5: Timeliness of UM Decisions

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

## Intent

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

## Summary of Changes

- Changed the time frame in factor 3 from "72 hours" to "24 hours."
- Revised the documentation and look-back period for factor 3.

## Element C: Notification of Pharmacy Decisions

**The organization adheres to the following time frames for notifying members and practitioners of pharmacy UM decisions:**

1. **For commercial and Exchange urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of the request.**
2. **For Medicare Part B and Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of the request.**
3. **For commercial and Exchange urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 ~~72~~ hours of the request.**
4. **For Medicare Part B and Medicaid urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of the request.**
5. **For commercial and Exchange nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 15 calendar days of the request.**
6. **For Medicare Part B nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.**
7. **For Medicaid nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of the request.**
8. **For postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 30 calendar days of the request.**
9. **For Medicare Part D urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of receipt of the request.**

10. **For Medicare Part D nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of receipt of the request.**
11. **For Medicare Part D postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 14 calendar days of receipt of the request.**

**Scoring**

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

**Data source** Records or files

**Scope of review**

**Product lines**

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

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

Factors 1–8 apply to commercial, Medicaid and Exchange product lines and Medicare Part B drugs.

**Documentation**

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

*For factor 3:* Urgent preservice decisions made before October 1, 2027, will be scored on the prior time frame of 72 hours.

Urgent preservice decisions made on or after October 1, 2027, will be scored on the 24-hour time frame.

**Look-back period**

*For First Surveys:* 6 months; for surveys on or after October 1, 2027, prior to the survey date for factor 3.

*For Renewal Surveys*: 12 months; for surveys on or after October 1, 2027, prior to the survey date for factor 3.

**Explanation**

**THIS IS A MUST-PASS ELEMENT.**

This element applies to all pharmaceutical denial determinations resulting from medical necessity review (as defined in *UM 1: Program Structure,* Element A), whether the pharmaceutical is covered under an organization's medical benefit or its pharmacy benefit.

### Dispute of file review results

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

### Definitions used when classifying UM requests

The organization uses the definitions stated in Element A.

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

### *Factors 2, 4, 7:* Timeliness of Medicaid pharmacy notification

For the Medicaid product line, drugs that meet the federal definition of "covered outpatient drugs" as stated in SSA 1927(k)(2), the organization sends its decision notification within 24 hours.

For the Medicaid product line, drugs that are excluded from the federal definition of "covered outpatient drugs," as stated in SSA 1927(k)(3), the organization sends its decision notification within 72 hours for urgent concurrent requests and urgent preservice requests, and sends its decision notification within 14 calendar days for nonurgent preservice requests.

### *Factors 1–11:* Timeliness of pharmacy notification

The organization notifies the member (or their authorized representative) and the member's attending or treating practitioner of the UM decision within the time frames specified in factors 1–11.

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

Under certain circumstances, the organization may address the notification to only the attending or treating practitioner. Refer to *Related information.*

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

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

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

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

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

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

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

**Exceptions**

This element is NA:

- If all purchasers of the organization's services carve out or exclude pharmaceutical management.
- For pharmaceutical approvals made at the pharmacy.

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

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

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

Factors 1–8 are NA for Medicare Part D drugs.

Factors 1, 3 and 5 are NA for Medicare and Medicaid product lines.

Factors 2 and 4 are NA for commercial and Exchange product lines.

Factor 6 is NA for commercial, Medicaid and Exchange product lines.

Factor 7 is NA for commercial, Medicare and Exchange product lines.

Factors 9–11 are NA for commercial, Medicaid and Exchange product lines and Medicare Part B drugs.

This element is NA for Interim Surveys.

**Related information**

*Addressing notices to only the attending or treating practitioner.* For preservice and postservice decisions, if attending or treating practitioner information was not provided with the request, or if the request was from a provider (e.g., facility), not from a practitioner, the organization 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 practitioner's name is not required).

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

*Medicare Part B drugs (factors 2, 4, 6).* For guidance on drugs covered under Medicare Part B, refer to the Medicare Managed Care Manual, Chapter 4 - Benefits and Beneficiary Protections, 10.8 – Drugs that are Covered Under Original Medicare Part B.

*Medicare Part D drugs (factors 9–11).* For guidance on drugs covered under Medicare Part D, refer to the Medicare Prescription Drug Benefit Manual Chapter 6 – Part D Drugs and Formulary Requirements, 10.2 - Covered Part D Drugs.

*Alignment with CMS time frames.*

- Factor 9: Medicare Part D urgent preservice decisions. The time frame corresponds to the CMS "expedited coverage" determination time frame.
- Factor 10: Medicare Part D nonurgent preservice decisions. The time frame corresponds to the CMS "standard coverage" determination time frame.
- Factor 11: Medicare Part D postservice decisions. The time frame corresponds to the CMS "request for reimbursement" time frame.

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

*Medications dispensed at the pharmacy.* Requests for coverage of medications dispensed at a pharmacy may only be classified as urgent concurrent, urgent preservice or nonurgent preservice, depending on whether the request meets NCQA's definition of "urgent." Medications dispensed at the pharmacy may not be classified as postservice requests.

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

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

*Extending time frames for factors 1–8*. Members or their authorized representatives may agree to extend the decision-making time frame for urgent, preservice and postservice requests.

### *Extension conditions*

Factor 1: Urgent concurrent requests for commercial and Exchange product lines.

- The organization may extend the decision notification time frame if the request to extend urgent concurrent care was made less than 24 hours prior to, or any time after, the expiration of the previously approved period or number of treatments. The organization may treat the request to extend urgent concurrent care as urgent preservice and send a decision notification within 72 hours.
- The organization may extend the decision notification time frame if the request to approve additional days for urgent concurrent care is related to care not previously approved by the organization and the organization documents that it made at least one attempt and was unable to obtain the needed clinical information within the initial 24 hours after the request for coverage of additional days. In this case, the organization has up to 72 hours to make the decision.

Factors 2, 4: Urgent concurrent and urgent preservice requests for Medicaid product line.

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

- The member requests an extension, ***or***
- The organization needs additional information, provided it documents that it made at least one attempt to obtain the necessary information.
- The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition

requires, but no later than the expiration of the extension.

Factor 3: Urgent preservice requests for commercial and Exchange product lines.

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

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

Factor 5: Nonurgent preservice requests for commercial and Exchange product lines.

If the request lacks clinical information, the organization may extend the nonurgent preservice time frame for up to 15 calendar days, under the following conditions:

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

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

Factor 7: Nonurgent preservice requests for Medicaid product line.

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

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

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

Factor 8: Postservice requests for commercial, Exchange and Medicaid product lines.

If the request lacks clinical information, the organization may extend the postservice time frame for up to 15 calendar days, under the following conditions:

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

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

Extension for other reasons.

In a situation beyond the organization's control (e.g., waiting for an evaluation by a specialist), it may extend the nonurgent preservice and postservice time frames once, for up to 15 calendar days, under the following conditions:

- Within 15 calendar days of a nonurgent preservice request, the organization notifies the member (or the member's authorized representative) of the

need for an extension and the expected date of the decision.

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

Extending time frames for Medicare Part B and D for factors 2, 4, 6, 9–11—Alignment with CMS.

In accordance with the Medicare Prescription Drug Manual, Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, extensions are not allowed.

*For Medicare,* extensions are not allowed for postservice requests.

Factors 1–4: Verbal notification of denials.

Verbal notification does not replace electronic or written notification of denial decisions, but when provided, the organization may extend the time frame for electronic or written notification for commercial, Medicare and Exchange decisions as described below.

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

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

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

*For Medicare Part D drugs,* initial verbal notification of a decision may be made within the specified time frames. Written notification must be made no later than 3 calendar days after verbal notification.

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

and informs them of the proper procedures to follow when requesting coverage.

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

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

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

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

- The organization informs practitioners of the notification mechanism and their responsibility to check the portal regularly, ***and***
- The organization documents the date and time when the information was posted in the portal, ***and***
- The information posted in the portal meets the requirements in UM 4–UM 7. If the portal contains a link to the information on a specific site, it must include a site description that gives readers a clear idea of its topic and general content, ***and***
- The organization must have an alternative method for practitioners who do not have access to the web portal.

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

- The organization documents the member's agreement to receive electronic notifications via the portal, ***and***
- The organization documents the date and time when the information was posted in the portal, ***and***
- Members receive notification that a new document or update is available in the portal when it is posted (e.g., text, email, other electronic notification), ***and***
- The information posted in the portal meets the requirements in UM 4–UM 7. If the portal contains a link to the information on a specific site, it must include a site description that gives readers a clear idea of its topic and general content, ***and***

- The organization has an alternative notification method for members who do not have access to the web portal or who do not agree to receive notifications via the portal.

**Examples** **Failure to follow filing procedures**

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

# UM 10: Procedures for Pharmaceutical Management

**The organization ensures that its procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals.**

## Intent

**The organization develops, regularly reviews and updates policies and procedures for pharmaceutical management based on sound clinical evidence.**

## Element A: Pharmaceutical Management Procedures

**The organization's policies and procedures for pharmaceutical management include the following:**

1. **The criteria used to adopt pharmaceutical management procedures.**
2. **A process to use clinical evidence from appropriate external organizations.**
3. **A process to include pharmacists and appropriate practitioners in the development of procedures.**
4. **A process to provide procedures to practitioners annually and when it makes changes.**

## Summary of Changes

- Removed Renewal Surveys from the scope of review and look-back period; made Renewal Surveys an exception.

**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

**Scope of review**

**Product lines**

*For Interim Surveys and First Surveys~~, and Renewal Surveys~~: This element applies to all product lines.*

**Documentation**

*For Interim Surveys and First Surveys ~~and Renewal Surveys~~:* NCQA reviews the organization's policies and procedures in place throughout the look-back period.

**Look-back period**

*For Interim Surveys:* Prior to the survey date.

*For First Surveys:* 6 months.

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

**Explanation**

This element applies to pharmaceuticals managed by the organization, whether they are covered under an organization's medical benefit or under its pharmacy benefit, including, but not limited to:

- All pharmaceuticals, even those not listed in the organization's formularies.
- Pharmaceuticals administered or dispensed in all settings (e.g., inpatient, outpatient, at the pharmacy, at home).
- Customized pharmaceutical management procedures for a distinct set or class of pharmaceuticals, including injectables.

The organization has pharmaceutical management procedures that promote the clinically appropriate use of pharmaceuticals, unless otherwise carved out by all purchasers of the organization's services.

If the organization does not manage certain aspects of this element (i.e., generic substitution, therapeutic interchange, step-therapy protocols), the organization's policies and procedures specify the aspects that do not apply.

***Factor 1:*** **Criteria for adoption**

Criteria for adopting pharmaceutical procedures are different from the clinical criteria used in medical necessity review and required in *UM 2: Clinical Criteria for UM Decisions*. In this element, NCQA reviews the organization's decision criteria for developing pharmaceutical management procedures as a whole.

The organization's policies and procedures specify that the criteria used when adopting the pharmaceutical management procedures, includes:

- Pharmaceutical classes.
- Classes preferred or covered at any level.
- Lists of preferred pharmaceuticals or formularies.
- Considerations for limiting access to drugs in certain classes.
- Prior authorization criteria.
- Generic substitution, therapeutic interchange, step therapy or other management methods to which the practitioner's prescribing decisions are subject.
- Within each class of pharmaceuticals:
  - Pharmaceuticals preferred or covered at any level.
  - An exceptions process available to members.
  - Substitutions made automatically or with permission of the prescribing practitioner.
  - Evidence that preferred-status pharmaceuticals can produce similar or better results for a majority of the population than other pharmaceuticals in the same class.
  - Other requirements, restrictions, limitations or incentives that apply to the use of certain pharmaceuticals.

***Factor 2:*** **Use of clinical evidence**

The organization's policies and procedures specify that to make pharmaceutical decisions, the organization uses clinical evidence from the following sources, as appropriate:

- Government agencies.
- Medical associations.
- National commissions.
- Peer-reviewed journals.
- Authoritative compendia.

***Factor 3:*** **Involvement of pharmacists and appropriate practitioners**

When reviewing and making periodic updates to the pharmaceutical management policies and procedures, the organization's pharmaceutical management committee involves:

- Clinical pharmacists.
- Appropriate practitioners.

The committee may be local, regional or national. If the committee is national, involvement of local practitioners is not required.

***Factor 4:*** **Distributing pharmaceutical management procedures**

The organization's policies and procedures specify that it distributes pharmaceutical management procedures to practitioners by mail, fax, email, or on its website, if it informs 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 has a process to mail pharmaceutical management procedures to practitioners who do not have fax, email or internet access.

**Exceptions**

This element is NA:

- If all purchasers of the organization's services carve out or exclude pharmaceutical management.
- For Renewal Surveys.

**Examples** None.

## Element B: Pharmaceutical Restrictions/Preferences

**Annually, and at least 30 calendar days before updates take effect, ~~and within 30 calendar days in advance of updates~~ the organization communicates to members and prescribing practitioners:**

1. **A list of pharmaceuticals, including restrictions and preferences.**
2. **How to use the pharmaceutical management procedures.**
3. **An explanation of limits or quotas.**
4. **How prescribing practitioners must provide information to support an exception request.**
5. **The organization's process for generic substitution, therapeutic interchange and step-therapy protocols.**

## Summary of Changes

**Clarification**

- Revised the element stem from "Annually, and within 30 calendar days in advance of updates" to "Annually, and at least 30 calendar days before updates take effect."

**Scoring**

| Met | Partially Met | Not Met |
|---|---|---|
| The organization meets 4-5 factors | The organization meets 2-3 factors | The organization meets 0-1 factors |

**Data source** Documented process, Reports, Materials

**Scope of review**

**Product lines**

*For Interim Surveys, First Surveys, and Renewal Surveys: This element applies to all product lines.*

**Documentation**

NCQA reviews the organization's pharmaceutical procedures and lists.

*For First Surveys and Renewal Surveys:* NCQA also reviews materials distributed to members and prescribing practitioners. The organization may also provide reports to show evidence of distribution to members and practitioners.

**Look-back period**

*For Interim Surveys:* Prior to the survey date.

*For First Surveys:* At least once during the prior year, and 6 months for notification of updates within 30 days.

*For Renewal Surveys:* 24 months, and 6 months for notification of updates within 30 days.

**Explanation**

This element applies to all pharmaceuticals, whether they are covered under an organization's medical benefit or under its pharmacy benefit, including, but not limited to:

- All pharmaceuticals, whether or not they are listed in the organization's formularies.
  - Including open and closed formularies.
- Pharmaceuticals administered or dispensed in all settings (e.g., inpatient, outpatient, at the pharmacy, at home).
- Customized pharmaceutical management procedures for a distinct set or class of pharmaceuticals, including injectables.

The organization has pharmaceutical management procedures that promote the clinically appropriate use of pharmaceuticals, unless otherwise carved out by all purchasers of the organization's services.

Pharmaceutical and pharmaceutical management procedures communicated to members and prescribers include information on, as applicable:

- Covered pharmaceuticals.
- Copayment information, including tiers.
- Pharmaceuticals that require prior authorization.
- Limits on refills, doses or prescriptions.
- Use of generic substitution, therapeutic interchange or step-therapy protocols.
- How formulary updates are communicated, and how often, if the organization has scheduled formulary updates.

**Distribution of pharmaceutical procedures and updates**

The organization distributes pharmaceutical procedures to all members and practitioners.

The organization may limit communication of updates to "negative" formulary changes (i.e., changes that result in restrictions or replacements) and may limit such communications to affected members and their practitioners.

Negative formulary changes include any of the following:

- Removing a drug from a formulary.
- Increasing cost-sharing status of a drug in the formulary.
- Adding, or making more restrictive:
  - Prior authorization requirements.
  - Quantity limits.
  - Step therapy requirements.
- Imposing other restrictions on a formulary drug.

The organization distributes pharmaceutical management procedures and updates by mail, fax, email, or on its website if it informs members and prescribing practitioners that the information is available online. The notice

must include a description specific enough to give readers a clear idea of the topic and the general content and must include a link or direction to the specific information. The organization may group or summarize the information by theme. The organization mails pharmaceutical management procedures and updates to prescribing practitioners and affected members who do not have fax, email or internet access.

***Factors 1–3***

No additional explanation required.

***Factor 4:* Exception request**

If the organization administers a closed formulary, there is an exception process for circumstances where the formulary does not adequately accommodate members' clinical needs, and a process for prescribing practitioners to submit information that supports exception requests.

***Factor 5:* Process for generic substitution, therapeutic interchange and step-therapy protocols**

The organization's procedures regarding generic substitution, therapeutic interchange and step-therapy are outlined and communicated to members and prescribers. The organization is not required to communicate procedures that are not in use within its benefit.

**Exceptions**

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

Factor 4 is NA for organizations that do not administer a closed formulary for their members.

**Examples**

**Negative formulary change**

- A drug requires prior authorization in 2026, but did not require it in 2025. The organization communicates this update to members.

**Pharmaceutical management procedures**

- Member and practitioner newsletters or handbooks describe changes to generic substitution, therapeutic interchange or step-therapy protocols.

## Element D: Reviewing and Updating Procedures

**With the participation of physicians and pharmacists, the organization annually:**

1. **Reviews the procedures.**
2. **Reviews the list of pharmaceuticals.**
3. **Updates the procedures as appropriate.**
4. **Updates the list of pharmaceuticals as appropriate.**

## Summary of Changes

- Retire this element for all survey types.

**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**

*For Interim Surveys, First Surveys and Renewal Surveys: This element applies to all product lines.*

**Documentation**

NCQA reviews the organization's policies and procedures.

*For First Surveys and Renewal Surveys:* NCQA also reviews pharmaceutical management committee minutes or similar documentation, and reviews updates to the pharmaceutical procedures, if applicable.

**Look-back period**

*For Interim Surveys:* Prior to the survey date.

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

*For Renewal Surveys:* 24 months.

**Explanation**

This element applies to all pharmaceuticals, whether they are covered under an organization's medical benefit or under its pharmacy benefit, including, but not limited to:

- All pharmaceuticals, even those not listed in the organization's formularies.
- Pharmaceuticals administered or dispensed in all settings (e.g., inpatient, outpatient, at the pharmacy, at home).
- Customized pharmaceutical management procedures for a distinct set or

class of pharmaceuticals, including injectables.

The organization has pharmaceutical management procedures that promote the clinically appropriate use of pharmaceuticals, unless otherwise carved out by all purchasers of the organization's services.

This element applies to pharmaceutical management procedures described in Elements A–C.

The organization may space its review and updates of pharmaceutical management procedures and list of approved pharmaceuticals over the course of the year.

**Involvement of physicians and pharmacists**

When reviewing and making periodic updates to the pharmaceutical management policies and procedures, the organization's pharmaceutical management committee involves:

- Clinical pharmacists.
- Appropriate physicians.

The committee may be local, regional or national. If the committee is national, involvement of local physicians or pharmacists is not required.

***Factors 1–4***

No additional explanation required.

**Exception**

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

**Examples** None.

## Element E: Considering Exceptions

**The organization has exceptions policies and procedures that describe the process for:**

1. **Making an exception request based on medical necessity.***
2. **Obtaining medical necessity information from prescribing practitioners.***
3. **Using appropriate pharmacists and practitioners to consider exception requests.**
4. **Timely handling of exception requests.**
5. **Communicating the reason for a denial and an explanation of the appeal process when it does not approve an exception request.**

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

## Summary of Changes

- Removed Renewal Surveys from the scope of review and look-back period; made Renewal Surveys an exception.

**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**

*For Interim Surveys and First Surveys ~~and Renewal Surveys~~: This element applies to all product lines.*

**Documentation**

NCQA reviews the organization's policies and procedures in place throughout the look-back period.

**Look-back period**

*For Interim Surveys:* Prior to the survey date.

*For First Surveys:* 6 months.

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

**Explanation**

This element applies to all pharmaceuticals, whether they are covered under an organization's medical benefit or under its pharmacy benefit, including, but not limited to:

- All pharmaceuticals, whether or not they are listed in the organization's formularies.
- Pharmaceuticals administered or dispensed in all settings (e.g., inpatient, outpatient, at the pharmacy, at home).
- Customized pharmaceutical management procedures for a distinct set or class of pharmaceuticals, including injectables.

The organization has pharmaceutical management procedures that promote the clinically appropriate use of pharmaceuticals, unless otherwise carved out by all purchasers of the organization's services.

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

**Formulary exceptions** are requests by members or their authorized representatives to obtain a pharmaceutical that is not included as part of the organization's closed formulary.

***Factor 1:*** **Exception for medical necessity**

The organization's policies and procedures allow members to request exceptions based on medical necessity if needed pharmaceuticals are not on the list of approved pharmaceuticals.

***Factor 2:*** **Obtaining information from prescribing practitioners**

The organization's policies and procedures detail the clinical information needed from prescribing practitioners in order to determine medical necessity.

***Factor 3:*** **Review by appropriate practitioner**

No additional explanation required.

***Factor 4:*** **Timely handling of exception requests**

The organization's policies and procedures provide time frames for exception requests. Time frames are not required to be the same as those stated in *UM 5: Timeliness of UM Decisions*, but must consider clinical urgency.

***Factor 5:*** **Denial notification and appeal rights**

The organization's policies and procedures specify that if the organization denies a request for an exception based on medical necessity, internal and external appeal processes are available on the same basis as for denials of other services.

**Exceptions**

This element is NA:

- If the organization does not administer a closed formulary for its members.
- If All purchasers of the organization's services carve out or exclude pharmaceutical management.
- For Renewal Surveys.

**Related information**

*Formulary exception appeals.* A denial of a formulary exception request is a coverage decision subject to appeal under the policies and procedures required under UM 8. Upheld appeals of formulary exception denials are included in the file universe in *UM 9: Appropriate Handling of Appeals*.

*Existing exception policies.* Many organizations and pharmacy benefit managers have exception policies in place; some use online or telephone systems to communicate with pharmacists and consider coverage for the prescribed pharmaceutical based on medical necessity. It is not the intent of this element to interfere with these processes; they meet the requirements of Element E if the organization's formal appeal process is available to members whose exception request was denied.

**Examples**

***Factor 1:*** **Reasons for exception requests**

- Intolerance or allergy to pharmaceuticals on the organization's list of approved drugs.
- Inadequate or inappropriate response to pharmaceuticals on the organization's list of approved drugs.

# ME 3: Marketing Information

**The organization ensures that communication with prospective members correctly and thoroughly represents the benefits and operating procedures of the organization.**

## Intent

**Prospective members receive an accurate description of the organization's benefits and operating procedures.**

## Element A: Materials and Presentations

**All organizational materials and presentations accurately describe the following information:**

1. **Covered benefits.**
2. **Noncovered benefits.**
3. **Practitioner and provider availability.**
4. **Key UM procedures the organization uses.**
5. **Potential network, service or benefit restrictions.**
6. **Pharmaceutical management procedures.**

## Summary of Changes

- Remove this element from Member Experience and move to the Medicaid Module.

**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**

*For all surveys: This element applies to the Medicaid product line only.*

*For Interim Surveys: This element applies to all product lines.*

*For First Surveys and Renewal Surveys: This element applies to the Medicaid product line only.*

**Documentation**

*For Interim Surveys:* Materials that have been approved by the organization but are not in final layout form are acceptable to meet the requirement.

NCQA reviews the organization's marketing information made available to prospective members within the look-back period.

**Look-back period**

*For Interim Surveys:* Prior to the survey date.

*For First Surveys:* 6 months.

*For Renewal Surveys:* 24 months.

**Explanation**

This element may not be delegated.

The organization ensures that members enroll with a realistic expectation of how it operates.

***Factors 1, 2***

No additional explanation required.

***Factor 3:* Availability**

The organization's marketing materials describe the networks or subnetworks of practitioners and providers that prospective members might access, and how to access them.

***Factor 4:* UM procedures**

UM procedures include, but are not limited to:

- Preservice review.
- Urgent concurrent review.
- Postservice review.
- Filing an appeal.

***Factor 5:* Potential restrictions**

No additional explanation required.

***Factor 6:* Pharmaceutical management procedures**

Marketing materials:

- Describe the organization's pharmaceutical management procedures.
- List pharmaceutical restrictions.
- Provide instructions for accessing pharmaceutical management procedures or checking coverage regarding a pharmaceutical.
- Describe the exceptions process for coverage of nonformulary pharmaceuticals, if the organization has a closed formulary.

**Exceptions**

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

This element is NA for Medicare or Exchange product lines if the organization has no control over marketing materials. The organization must provide documentation demonstrating this restriction.

This element is NA for the Medicaid product line if:

- The organization has no control over its marketing materials, ***or***
- The organization does not communicate with or market to prospective members and does not submit information to a centralized location for prospective members to compare plans.
  - The organization provides documentation of the restriction or a policy that it does not market to prospective members.

**Examples** None.

## Element B: Communicating With Prospective Members

**The organization uses easy-to-understand language in communications to prospective members about its policies and practices regarding collection, use and disclosure of PHI:**

1. **In routine notification of privacy practices.**
2. **The right to approve the release of information (use of authorizations).**
3. **Access to medical records.**
4. **Protection of oral, written and electronic information across the organization.**
5. **Information for employers.**

## Summary of Changes

- Remove this element from Member Experience and move to the Medicaid Module.

**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** Materials

**Scope of review**

**Product lines**

*For Interim all surveys: This element applies to the Medicaid product line only. all product lines.*

*For First Surveys and Renewal Surveys: This element applies to the Medicaid product line only.*

**Documentation**

*For Interim Surveys:* Materials that have been approved by the organization but are not in final layout form are acceptable to meet the requirement.

NCQA reviews the organization's materials containing PHI use and disclosure policies and procedures communicated to prospective members throughout the look-back period.

**Look-back period**

*For Interim Surveys:* Prior to the survey date.

*For First Surveys:* 6 months.

*For Renewal Surveys:* 24 months.

**Explanation**

This element may not be delegated.

***Factors 1–4***

No additional explanation required.

***Factor 5:* Information for employers**

The organization explains what information it shares with employers or purchasers.

**Exceptions**

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

This element is NA for the Medicare and Exchange product line if the organization has no control over marketing materials. The organization must provide documentation demonstrating this restriction.

This element is NA for the Medicaid product line if:

- The organization has no control over its marketing materials, ***or***
- The organization does not communicate with or market to prospective members and does not submit information to a centralized location for prospective members to compare plans.
  - The organization provides documentation of the restriction or a policy that it does not market to prospective members.

Factor 5 is NA:

- For product lines sponsored by state or federal government (e.g., Medicare, Medicaid, Federal Employee Health Benefits [FEHB]).
- If the organization does not disclose information to plan sponsors.
- For individual and family plans offered under the Exchange product line.

**Examples**

None.

## Element C: Assessing Member Understanding

~~**The organization systematically takes the following steps:**~~

~~**1. Assesses how well new members understand policies and procedures.**~~

~~**2. Implements procedures to maintain accuracy of marketing communication.**~~

~~**3. Acts on opportunities for improvement, if applicable.**~~

## Summary of Changes

- Remove this element from Member Experience and move to the Medicaid Module.

**~~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**~~

~~*For First Surveys and Renewal Surveys: This element applies to the Medicaid product line only.*~~

~~**Documentation**~~

~~*For factors 1, 2:* NCQA reviews evidence that the organization completed the required activities at least once during the look-back period.~~

~~*For factor 3:* NCQA reviews evidence that the organization took action at least once during the look-back period, if applicable.~~

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

**~~Explanation~~** ~~This element may not be delegated.~~

~~The organization specifies how often it collects member feedback. If assessment of feedback shows that new members do not have an accurate understanding of the organization's policies and procedures, the organization initiates a quality improvement process to clarify its policies and procedures.~~

~~***Factor 1:*** **Assessing understanding of policies and procedures**~~

~~The organization assesses how well new members understand its policies and procedures.~~

~~Assessing understanding through complaint/appeal data alone does not meet the intent of the factor. The assessment should also include inquiries about the organization's policies and procedures, or use an additional method (e.g., surveys, focus groups) to obtain feedback.~~

~~***Factors 2, 3:*** **Implementing procedures and acting on opportunities**~~

~~No additional explanation required.~~

**Exceptions**

This element is NA for Interim Surveys.

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

This element is NA for the Medicare and Exchange product line if the organization has no control over marketing materials. The organization must provide documentation demonstrating this restriction.

This element is NA for the Medicaid product line if:

- The organization has no control over its marketing materials, ***or***
- The organization does not communicate with or market to prospective members and does not submit information to a centralized location for prospective members to compare plans.
  - The organization provides documentation of the restriction or a policy that it does not market to prospective members.

Factor 3 is NA if the organization has no opportunities to improve member understanding. NCQA evaluates whether this conclusion is reasonable, given assessment results.

**Examples**

***Factor 1:*** **Assessment**

*Topics to assess member understanding:*

- Benefits coverage.
- How to file an appeal.
- How to select a primary care practitioner.
- In-network vs. out-of-network benefits.

*Methods for obtaining feedback:*

- Survey new members.
- Surveys conducted through employers.
- Focus groups.
- Assess of inquiries and complaints by new members.

# ME 4: 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

- Retire this element for all survey types.

**Scoring**

| Met | Partially Met | Not Met |
|---|---|---|
| The organization meets 4-5 factors | The organization meets 2-3 factors | The organization meets 0-1 factors |

**Data source**

Documented process, Reports, Materials

**Scope of review**

**Product lines**

*For First Surveys: This element applies to all product lines.*

**Documentation**

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 ID, NCQA reviews the organization's website or screenshots of web functionality, supplemented with documents specifying the required features and functions of the site. If screenshots include detailed explanations of how the site works, there is no need to provide supplemental documents.

**Look-back period**

*For First Surveys:* 6 months.

**Explanation**

The organization provides evidence that it can perform all activities required by this element, even if no employers or plan sponsors purchase the services.

The organization meets the requirement of "one attempt or contact" if:

- Members can access all required website functions 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 claims process on the organization's website. NCQA does not review individual claims, and expects that data are present only if applicable to a stage in the 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 for Interim Surveys and Renewal Surveys.

This element is NA:

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

*Use of live chat.* The use of a live chat feature on the organization's website is acceptable if members can obtain the information in one attempt or contact.

**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

- Retire this element for all survey types.

**Scoring**

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

**Data source**

Documented process, Reports, Materials

**Scope of review**

**Product lines**

*For First Surveys: This element applies to all product lines.*

**Documentation**

NCQA reviews evidence that 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 First Surveys:* 6 months.

**Explanation**

The organization provides evidence that it can perform the activities required by this element, even if no employers or plan sponsors purchase the services.

The organization meets the requirements for all five factors, even if a factor does not apply to a specific claim. A notation may be made in the organization's system regarding claim status (e.g., pending, 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 1 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**

The date when the claim is processed for payment or the check is cut.

**Exceptions**

This element is NA for Interim Surveys and Renewal Surveys.

**Evidence of the claims process by telephone**

**Examples**

- Tracking logs that contain responses to applicable factors.
- Decision-tree script provided to Member Services staff.

# ME 5: Pharmacy Benefit Information

**The organization provides members with the information they need to understand and use their pharmacy benefit.**

## Intent

**The organization uses its website and telephone communication to inform members about their pharmacy benefit, their financial responsibility for medications and the operations of network pharmacies.**

## Element A: Pharmacy Benefit Information: Website

**Members can complete the following actions on the organization's website in one attempt or contact:**

1. **Determine their financial responsibility for a drug, based on the pharmacy benefit.**
2. **Initiate the exceptions process.**
3. **Order a refill for an existing, unexpired mail-order prescription.**
4. **Find the location of an in-network pharmacy.**
5. **Conduct a pharmacy proximity search based on ZIP code.**
6. **Determine the availability of generic substitutes.**

## Summary of Changes

- Retire this element for all survey types.

**Scoring**

| Met | Partially Met | Not Met |
|---|---|---|
| The organization meets 5-6 factors | The organization meets 2-4 factors | The organization meets 0-1 factors |

**Data source**

Documented process, Reports, Materials

**Scope of review**

**Product lines**

*For First Surveys: This element applies to all product lines.*

**Documentation**

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 screenshots of web functionality, supplemented with documents specifying the required features and functions of the site. If screenshots provided include

detailed explanations of how the site works, there is no need to provide supplemental documents.

**Look-back period**

*For First Surveys:* 6 months.

**Explanation**

The organization has the capability to meet the requirements of this element, even if no employers or plan sponsors purchase the services.

**One attempt or contact**

The organization meets the requirement of "one attempt or contact" if:

- Members can access all required website functions in one session without the need to sign in again on the organization's website or contact the organization.
- The website contains a direct link to the organization's pharmacy benefit manager, or to a similar organization that performs the functions in factors 1–6.

**Note:** If the organization's website directs members to the pharmacy website, where members are directed to log-in again, this is acceptable and counts as one attempt or contact.

***Factor 1:*** **Financial responsibility**

The organization's website:

- Allows members to enter a pharmaceutical name, the National Drug Code (NDC) or another identifier.
- Calculates a member's financial responsibility (e.g., out-of-pocket cost associated with filling a prescription) for a listed medication, based on the member's pharmacy benefit.
    - The organization's website may display a statement that because of frequent changes in the price of medications, financial information provided on the site may not be exact.

If members have no financial responsibility for any medications, the organization meets the requirement if it posts a generic statement on its website informing members that they have no financial responsibility.

If members have the same flat copay for all medications (copay does not vary by tier, drug class, injectables), the organization meets the requirement if it posts a generic statement on its website informing members that there is a flat copay, including the dollar amount, for all medications. The only acceptable variation is days supply (e.g., 30-days vs. 90-days supply).

***Factor 2:*** **Exceptions process**

The organization's website has an exceptions process for reviewing member requests for noncovered pharmaceuticals when the formulary does not adequately accommodate their clinical needs. The exceptions process can resolve an issue before it reaches the level of a formal appeal.

Members (or their authorized representative) can initiate the exceptions process without having to go through a dispensing pharmacist's online system. Limiting the process to initiate the exceptions process to only practitioners does not meet the factor.

The organization has an exceptions process, even if it also has a process for communicating online with a dispensing pharmacist about an exception to a prescribed pharmaceutical.

***Factor 3:*** **Mail-order prescription refills**

The organization's website allows members to order a refill of an existing, unexpired mail-order prescription (if allowed by law). The organization determines which pharmaceuticals are available by mail and is not required to make all prescription medications available by mail.

***Factors 4, 5:*** **Location and proximity search**

No additional explanation required.

***Factor 6:*** **Availability of generic substitutes**

Members can enter the name of a specific pharmaceutical on the organization's website to retrieve a list of available generic medication substitutes for a specific pharmaceutical.

**Exceptions**

This element is NA:

- For Interim Surveys and Renewal Surveys.
- If all purchasers of the organization's services carve out or exclude the pharmacy benefit.

Factor 2 is NA if the organization has open formularies (i.e., all drugs are allowed).

Factor 3 is NA if the organization does not offer a mail-order service.

**Related information**

*Use of vendors.* NCQA considers the use of a PBM or contracting with a similar

organization to be delegation, except for factors 3–5.

*Factors 3–5:* NCQA does not consider it to be delegation if the organization contracts with pharmacies and provides a link to the pharmacy's website. Delegation oversight is not required under *ME 8: Delegation of ME.* Refer to *Vendors* in *Appendix 2: Delegation and Automatic Credit Guidelines.*

*Use of live chat.* The use of a live chat feature on the organization's website is acceptable if members can obtain information in one attempt or contact.

**Examples**

***Factor 1:* Financial responsibility**

The organization's website contains the following statements:

- Medicaid beneficiaries have no copay for any prescription. CHIP beneficiaries have a $10 copay for each prescription every time the prescription is filled.
- Medicaid beneficiaries have no copay for any prescription. CHIP beneficiaries have a $5 copay for prescriptions up to a 30-days supply for each prescription every time the prescription is filled and a $10 copay for prescriptions with a 31–90-days supply for each prescription every time the prescription is filled.

## Element B: Pharmacy Benefit Information: Telephone

**Members can complete the following actions via telephone in one attempt or contact:**

1. **Determine their financial responsibility for a drug, based on the pharmacy benefit.**
2. **Initiate the exceptions process.**
3. **Order a refill for an existing, unexpired, mail-order prescription.**
4. **Find the location of an in-network pharmacy.**
5. **Conduct a proximity search based on ZIP code.**
6. **Determine the availability of generic substitutes.**

## Summary of Changes

- Retire this element for all survey types.

**Scoring**

| Met | Partially Met | Not Met |
|---|---|---|
| The organization meets 5-6 factors | The organization meets 2-4 factors | The organization meets 0-1 factors |

**Data source** Documented process, Reports, Materials

**Scope of** **Product lines**

**review**

*For First Surveys: This element applies to all product lines.*

**Documentation**

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 First Surveys:* 6 months.

**Explanation**

The organization has the capability to meet the requirements, even if it does not provide services to any employer or plan sponsor.

**One attempt or contact**

The organization meets the requirement of "one attempt or contact" if members can complete all the required functions by telephone without the need 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**

The organization may implement a system where calls received after normal business hours are returned on the next business day, but calls received after midnight on Monday–Friday are responded to on the same business day. If the organization does not have a voicemail system, it has another method of tracking calls that are received after normal business hours, and returns those calls on the next business day.

***Factor 1:*** **Financial responsibility**

Members can determine their financial responsibility (e.g., out-of-pocket cost

associated with filling a prescription) for specified pharmaceuticals by telephone. The organization may inform members that financial information provided over the telephone may not be exact (e.g., because of frequent changes in the price of medications).

***Factor 2:*** **Exceptions process**

The organization has an exceptions process for reviewing member requests for noncovered pharmaceuticals when the formulary does not adequately accommodate their clinical needs. The exceptions process can resolve an issue before it reaches the level of a formal appeal.

Eligible individuals (or their authorized representative) can initiate the exceptions process on their own behalf without having to go through a dispensing pharmacist's telephone system. Limiting the process to initiate the exceptions process to only practitioners does not meet the factor.

***Factor 3:*** **Mail-order prescription refills**

Members can order a refill of an existing, unexpired mail-order prescription (if allowed by law).

The organization determines which pharmaceuticals are available by mail and is not required to make all prescription medications available by mail.

***Factors 4, 5:*** **Location and proximity search**

No additional explanation required.

***Factor 6:*** **Availability of generic substitutes**

Members can access information by telephone on the availability of generic substitutes for specific pharmaceuticals.

**Exceptions**

- For Interim Surveys and Renewal Surveys.
- If all purchasers of the organizations carve out or exclude the pharmacy benefit.

Factor 2 is NA if the organization has open formulary where all drugs are allowed.

Factor 3 is NA if the organization does not offer mail-order services.

**Related information**

*Factor 6: Clinical information.* Member Services staff are not expected to answer clinical questions. Members may receive a return call from a pharmacist or

clinician within 24 hours or may be transferred directly to a pharmacist or clinician.

**Examples** None.

## Element C: Pharmacy Benefit Updates

**The organization updates member pharmacy benefit information on its website and in materials used by telephone staff, as of the effective date of a formulary change and as new drugs are made available or are recalled.**

## Summary of Changes

- Retire this element for all survey types.

**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, Materials

**Scope of review**

**Product lines**

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

**Documentation**

NCQA reviews the organization's policies and procedures for updating pharmacy benefit information, and reviews three materials as evidence of updates throughout the look-back period, or reviews all materials if the organization has fewer than three.

**Look-back period**

*For First Surveys:* 6 months.

*For Renewal Surveys:* 24 months.

**Explanation**

**Pharmacy benefit information updates**

The organization updates members' pharmacy benefit information as of the effective date of changes to the formulary (i.e., due to the availability of new drugs and withdrawal or recall of pharmaceuticals). Updates include those related to formulary tiers, copays, limitations and exclusions. The organization updates both its website and materials used by staff to meet the requirement.

**Exceptions**

This element is NA:

- For Interim Surveys.
- If all purchasers of the organization's services carve out or exclude the pharmacy benefit.

**Related information**

*Immediate formulary changes, recalled or withdrawn drugs*. For immediate formulary changes or recalled or withdrawn drugs, NCQA does not require the organization to update pharmacy benefit information on its website as of the effective date. Updates to benefit information should occur as soon as possible.

**Examples** None.

# ME 6: Personalized Information on Health Plan Services

**The organization provides members with the information they need to easily understand and use health plan benefits.**

## Intent

**The organization makes it easy for members to decide how to use their benefits.**

## Element A: Functionality: Website

**Members can complete each of the following activities on the organization's website in one attempt or contact:**

1. **Change a primary care practitioner, as applicable.**
2. **Determine how and when to obtain referrals and authorizations for specific services, as applicable.**
3. **Determine benefit and financial responsibility for a specific service or treatment from a specified provider or institution, if applicable.**

## Summary of Changes

- Removed Renewal Surveys from the scope of review and look-back period; made Renewal Surveys an exception.

**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**

*For First Surveys ~~and Renewal Surveys~~: This element applies to all product lines.*

**Documentation**

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 ID, NCQA reviews the organization's website or screenshots of web functionality, supplemented with documents specifying the required features and functions of the site. If screenshots include detailed explanations of how the site works, there is no need to provide supplemental documents.

**Look-back period**

*For First Surveys:* 6 months.

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

**Explanation**

The organization meets the requirement of "one attempt or contact" if:

- Members can access all required website functions 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:*** **Changing a primary care practitioner**

Members can change or select a primary care practitioner on the organization's website in one attempt or contact.

The organization receives credit for this factor if it does not require members to select a primary care practitioner (i.e., members may see any primary care practitioner in the benefits plan). The organization must provide documentation to support this.

***Factor 2:*** **Referrals and authorizations**

If the organization requires a referral for services other than primary care, its website contains instructions for obtaining a referral, and lists necessary authorizations.

The organization receives credit for this factor if it does not require referrals or authorizations for members for any services or procedures. The organization must provide documentation to support this.

***Factor 3:*** **Benefit and financial responsibility**

The organization provides pricing for all services available to members under its medical benefit. Financial estimates may be a range based on local market cost or average negotiated rates. The organization may communicate that such information does not constitute approval or authorization for a service.

An interactive website that allows members to enter specific information meets the requirements of this factor. In order to provide accurate information, the organization may require a process where members provide the relevant CPT code.

The organization is not required to consider members' deductible or out-of-pocket maximum expense when estimating financial responsibility, but it should communicate this to members and explicitly state the difference in financial responsibility between in-network benefits and out-of-network benefits, and that members may be responsible for charges above approved rates.

**Exceptions**

This element is NA for Interim Surveys <u>and Renewal Surveys</u>.

Factor 3 is NA if:

- 90% or more of the organization's claims payments (as measured in dollars, rather than number of claims processed or number of members) are for services under capitation, and the member has no financial responsibility beyond a flat copay, ***or***
- 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 copay 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 live chat.* The use of a live chat feature on the organization's website is acceptable if members can obtain the information in one attempt or contact.

**Examples** None.

## Element B: Functionality: Telephone

**To support financial decision making, members can complete each of the following activities over the telephone within 1 business day:**

1. **Determine how and when to obtain referrals and authorizations for specific services, as applicable.**
2. **Determine benefit and financial responsibility for a specific service or treatment from a specified provider or institution.**

## Summary of Changes

- Removed Renewal Surveys from the scope of review and look-back period; made Renewal Surveys an exception.

**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**

*For First Surveys ~~and Renewal Surveys~~: This element applies to all product lines.*

**Documentation**

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.

**Look-back period**

*For First Surveys:* 6 months.

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

**Explanation**

The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.

Members can complete the activity within 1 business day. The organization may use live-person telephone transfers to another person or organization.

Calls received after normal business hours are returned within 1 business day. Calls received after midnight are responded to on the same business day. If the organization does not have a voicemail system, it has another method of tracking calls received after normal business hours, and returns those calls on the next business day.

***Factor 1:*** **Referrals and authorizations**

The organization receives credit for this factor if it does not require referrals or authorizations.

***Factor 2:*** **Benefit and financial responsibility**

The organization provides pricing for all services available to members under its medical benefit. Financial estimates may be a range based on local market cost or average negotiated rates. The organization may communicate that such information does not constitute approval or authorization for the service.

In order to provide accurate information, the organization may require members to provide the relevant CPT code.

The organization is not required to consider members' deductible or out-of-pocket maximum expense when estimating financial responsibility, but it should communicate this to members and explicitly state the difference in financial responsibility between in-network benefits and out-of-network benefits and that members may be responsible for charges above approved rates.

**Exceptions**

This element is NA for Interim Surveys <u>and Renewal Surveys.</u>

**Examples** **Evidence**

- Policies and procedures, supplemented with call scripts.
- Documentation of resources available to Member Services.

# ME 7: Member Experience

**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 C: Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals

**Using valid methodology, the organization annually categorizes and analyzes nonbehavioral complaints and appeals. ~~for each of the five required categories.~~**

## Summary of Changes

- Removed the requirement to aggregate complaints and appeals into five categories.

**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**

*For First Surveys and Renewal Surveys: This element applies to 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 annual data collection and analysis report.

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

**Look-back period**

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

*For Renewal Surveys:* 24 months.

**Explanation**

**Analysis of nonbehavioral complaints and appeals**

The organization collects and analyzes data for complaints and appeals separately.

The organization collects data on member complaints and appeals from the entire population of members, or draws statistically valid samples from the member population. If the organization use a member sample, it describes the sample universe and the sampling methodology.

The organization collects data from all sources of members' complaints and appeals, including:

- Noncoverage appeals addressed in Element A and Element B.
- 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 categories.

~~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 internal purposes, but for NCQA evaluation, it must aggregate and analyze all complaint and appeal data in only the five reporting categories above. The use of additional categories for NCQA reporting is not acceptable.~~

~~The organization must report results on each category, even if there are no complaints or appeals for a category.~~

**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 the Glossary appendix for the full definition of and requirements for *quantitative analysis* and *qualitative analysis*.

**Exception**

Noncoverage appeals are NA for the Medicare product line.

**Examples**

**Complaint and appeal types**

*Quality of Care*

- A member complained that a practitioner misdiagnosed a condition.

*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. The request was denied and 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 complained that participating practitioners lacked available appointments.
- A member complained that a primary care practitioner refused to make a specialist referral. The member appealed to the organization to allow the referral.

*Attitude and Service*

- A member complained that a practitioner was rude and used abusive language.
- A member complained that there was a 30-minute wait 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.

***Note:*** *Complaint and appeal types (examples only):*

- *The complaint and appeal types listed above are illustrative examples intended to show the range of issues an organization may analyze.*
- *Organizations are not required to use these categories, and may define categories that align with their own complaint and appeal classification systems, as long as they support meaningful analysis and identification of trends.*

***Table 1: Complaint volume report***

| Category | PREVIOUS MEASUREMENT YEAR | | CURRENT MEASUREMENT YEAR | |
|---|---|---|---|---|
| | Total Complaints | Complaints per 1,000 Members (Total: 300,000) | Total Complaints | Complaints per 1,000 Members (Total: 240,000) |
| Quality of Care | 1,462 | 4.87 | 1,323 | 5.51 |
| Access | 1,075 | 3.58 | 1,416 | 5.90 |
| Attitude/Service | 946 | 3.15 | 951 | 3.96 |
| Billing/Financial | 817 | 2.72 | 785 | 3.27 |

| Category | PREVIOUS MEASUREMENT YEAR | | CURRENT MEASUREMENT YEAR | |
|---|---|---|---|---|
| | Total Complaints | Complaints per 1,000 Members (Total: 300,000) | Total Complaints | Complaints per 1,000 Members (Total: 240,000) |
| Quality of Practitioner Office Site | 431 | 1.44 | 413 | 1.72 |
| Total/Number per 1,000 | 4,731 | 15.77 | 4,888 | 20.37 |

***Table 2: Appeal volume report***

| Category | PREVIOUS MEASUREMENT YEAR | | CURRENT MEASUREMENT YEAR | |
|---|---|---|---|---|
| | Total Appeals | Appeals per 1,000 Members (Total: 300,000) | Total Appeals | Appeals per 1,000 Members (Total: 240,000) |
| Quality of Care | 203 | 0.68 | 185 | 0.77 |
| Access | 121 | 0.40 | 98 | 0.41 |
| Attitude/Service | 83 | 0.28 | 86 | 0.36 |
| Billing/Financial | 91 | 0.30 | 78 | 0.33 |
| Quality of Practitioner Office Site | 68 | 0.23 | 63 | 0.26 |
| Total/Average | 566 | 1.89 | 510 | 2.13 |

## Element E: Annual Assessment of Behavioral Healthcare and Services

**Using valid methodology, the organization annually:**

1. **Evaluates behavioral healthcare member complaints and appeals. ~~for each of the five required categories.~~**
2. **Conducts a member experience survey.**

## Summary of Changes

- Removed requirement to aggregate complaints and appeals into five required categories.

**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**

*For First Surveys and Renewal Surveys: This element applies to 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 annual data collection and member experience survey report.

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

**Look-back period**

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

*For Renewal Surveys:* 24 months.

**Explanation**

***Factor 1:* Member complaints and appeals**

The organization collects data for complaints and appeals separately.

The organization collects data on member complaints and appeals from the entire population of members who have used behavioral healthcare services, 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 members' complaints and appeals, including:

- Noncoverage appeals addressed in Element A and Element B.
- 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 categories.

~~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 internal purposes, but for NCQA evaluation, it must aggregate and analyze all complaint and appeal data in only the five reporting categories above. The use of additional categories for NCQA reporting is not acceptable.~~

~~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.

**Exceptions**

This element is NA:

- For Interim Surveys.
- If all purchasers of the organization's services carve out or exclude behavioral healthcare services.
- Noncoverage appeals are NA for the Medicare product line.

**Examples**

**Complaint and appeal types**

*Quality of Care*

- Dissatisfaction with care provided by a behavioral healthcare practitioner.

*Access*

- Denial of visits to a nonparticipating practitioner resulting from the member's difficulty finding or scheduling visits with a participating provider.

*Attitude and Service*

- Failure to release medical records.
- Long office wait time.

*Billing and Financial Issues*

- Denials due to incorrect coding by practice staff.

*Quality of Practitioner Office Site*

- Exam rooms do not provide enough privacy.
- Waiting room seating is limited.
- The treatment setting is not safe.

***Note:*** *Complaint and appeal types (examples only):*

- *The complaint and appeal types listed above are illustrative examples intended to show the range of issues an organization may analyze.*
- *Organizations are not required to use these categories, and may define categories that align with their own complaint and appeal classification systems, as long as they support meaningful analysis and identification of trends.*

# MED 15: Marketing Information

**The organization ensures that communication with prospective members correctly and thoroughly represents the benefits and operating procedures of the organization.**

## Intent

**Prospective members receive an accurate description of the organization's benefits and operating procedures.**

## Element A: Materials and Presentations

**All organizational materials and presentations accurately describe the following information:**

1. **Covered benefits.**
2. **Noncovered benefits.**
3. **Practitioner and provider availability.**
4. **Key UM procedures the organization uses.**
5. **Potential network, service or benefit restrictions.**
6. **Pharmaceutical management procedures.**

## Summary of Changes

- This element was previously ME 3, Element A.

**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**

*For all surveys: This element applies to the Medicaid product line only.*

~~*For Interim Surveys: This element applies to all product lines.*~~

~~*For First Surveys and Renewal Surveys: This element applies to the Medicaid product line only.*~~

**Documentation**

*For Interim Surveys:* Materials that have been approved by the organization but are not in final layout form are acceptable to meet the requirement.

NCQA reviews the organization's marketing information made available to prospective members within the look-back period.

**Look-back period**

*For Interim Surveys:* Prior to the survey date.

*For First Surveys:* 6 months.

*For Renewal Surveys:* 24 months.

**Explanation**

This element may not be delegated.

The organization ensures that members enroll with a realistic expectation of how it operates.

***Factors 1, 2***

No additional explanation required.

***Factor 3:* Availability**

The organization's marketing materials describe the networks or subnetworks of practitioners and providers that prospective members might access, and how to access them.

***Factor 4:* UM procedures**

UM procedures include, but are not limited to:

- Preservice review.
- Urgent concurrent review.
- Postservice review.
- Filing an appeal.

***Factor 5:* Potential restrictions**

No additional explanation required.

***Factor 6:* Pharmaceutical management procedures**

Marketing materials:

- Describe the organization's pharmaceutical management procedures.
- List pharmaceutical restrictions.
- Provide instructions for accessing pharmaceutical management procedures or checking coverage regarding a pharmaceutical.
- Describe the exceptions process for coverage of nonformulary pharmaceuticals, if the organization has a closed formulary.

**Exceptions**

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

~~This element is NA for Medicare or Exchange product lines if the organization has no control over marketing materials. The organization must provide documentation demonstrating this restriction.~~

This element is NA for the Medicaid product line if:

- The organization has no control over its marketing materials, ***or***
- The organization does not communicate with or market to prospective members and does not submit information to a centralized location for prospective members to compare plans.
  – The organization provides documentation of the restriction or a policy that it does not market to prospective members.

**Examples** None.

## Element B: Communicating With Prospective Members

**The organization uses easy-to-understand language in communications to prospective members about its policies and practices regarding collection, use and disclosure of PHI:**

1. **In routine notification of privacy practices.**
2. **The right to approve the release of information (use of authorizations).**
3. **Access to medical records.**
4. **Protection of oral, written and electronic information across the organization.**
5. **Information for employers.**

## Summary of Changes

- This element was previously ME 3, Element B.

**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** Materials

**Scope of review**

**Product lines**

*For ~~Interim~~ all surveys: This element applies to the Medicaid product line only. ~~all product lines.~~*

*~~For First Surveys and Renewal Surveys: This element applies to the Medicaid product line only.~~*

**Documentation**

*For Interim Surveys:* Materials that have been approved by the organization but are not in final layout form are acceptable to meet the requirement.

NCQA reviews the organization's materials containing PHI use and disclosure policies and procedures communicated to prospective members throughout the look-back period.

**Look-back period**

*For Interim Surveys:* Prior to the survey date.

*For First Surveys:* 6 months.

*For Renewal Surveys:* 24 months.

**Explanation**

This element may not be delegated.

***Factors 1–4***

No additional explanation required.

***Factor 5:* Information for employers**

The organization explains what information it shares with employers or purchasers.

**Exceptions**

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

~~This element is NA for the Medicare and Exchange product line if the organization has no control over marketing materials. The organization must provide documentation demonstrating this restriction.~~

This element is NA for the Medicaid product line if:

- The organization has no control over its marketing materials, ***or***
- The organization does not communicate with or market to prospective members and does not submit information to a centralized location for prospective members to compare plans.
  - The organization provides documentation of the restriction or a policy that it does not market to prospective members.

Factor 5 is NA:

- For product lines sponsored by state or federal government (e.g., Medicare, Medicaid, Federal Employee Health Benefits [FEHB]).
- If the organization does not disclose information to plan sponsors.
- ~~For individual and family plans offered under the Exchange product line.~~

**Examples**

None.

## Element C: Assessing Member Understanding

**The organization systematically takes the following steps:**

1. **Assesses how well new members understand policies and procedures.**
2. **Implements procedures to maintain accuracy of marketing communication.**
3. **Acts on opportunities for improvement, if applicable.**

## Summary of Changes

- This element was previously ME 3, Element C.

**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**

*For First Surveys and Renewal Surveys: This element applies to the Medicaid product line only.*

**Documentation**

*For factors 1, 2:* NCQA reviews evidence that the organization completed the required activities at least once during the look-back period.

*For factor 3:* NCQA reviews evidence that the organization took action at least once during the look-back period, if applicable.

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

**Explanation** This element may not be delegated.

The organization specifies how often it collects member feedback. If assessment of feedback shows that new members do not have an accurate understanding of the organization's policies and procedures, the organization initiates a quality improvement process to clarify its policies and procedures.

***Factor 1:* Assessing understanding of policies and procedures**

The organization assesses how well new members understand its policies and procedures.

Assessing understanding through complaint/appeal data alone does not meet the intent of the factor. The assessment should also include inquiries about the organization's policies and procedures, or use an additional method (e.g., surveys, focus groups) to obtain feedback.

***Factors 2, 3:* Implementing procedures and acting on opportunities**

No additional explanation required.

**Exceptions**

This element is NA for Interim Surveys.

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

~~This element is NA for the Medicare and Exchange product line if the organization has no control over marketing materials. The organization must provide documentation demonstrating this restriction.~~

This element is NA for the Medicaid product line if:

- The organization has no control over its marketing materials, ***or***
- The organization does not communicate with or market to prospective members and does not submit information to a centralized location for prospective members to compare plans.
  - The organization provides documentation of the restriction or a policy that it does not market to prospective members.

Factor 3 is NA if the organization has no opportunities to improve member understanding. NCQA evaluates whether this conclusion is reasonable, given assessment results.

**Examples**

***Factor 1:*** **Assessment**

*Topics to assess member understanding:*

- Benefits coverage.
- How to file an appeal.
- How to select a primary care practitioner.
- In-network vs. out-of-network benefits.

*Methods for obtaining feedback:*

- Survey new members.
- Surveys conducted through employers.
- Focus groups.
- Assess of inquiries and complaints by new members.