2011 NCQA Health Plan Accreditation Requirements

What does NCQA look for when reviewing plans?

Quality Management and Improvement (QI)

Utilization Management (UM)

Credentialing and Recredentialing (CR)

Members' Rights and Responsibilities (RR)

Standards for Member Connections (MEM)

Medicaid Benefits and Services (MED)

HEDIS/CAHPS Performance Measures

Quality Management and Improvement (QI)

1. **Program Structure (QI 1)**
   - Does the plan have a written description of its QI program that is reviewed and updated annually?
   - Does the QI program specifically address behavioral health?
   - Is the QI program accountable to a governing body?
   - Does a QI Committee oversee the QI program?
   - Is there a physician and behavioral health practitioner involved in the QI program?
   - Are the roles, structures and functions of the QI Committee and other committees described in the QI program description?
   - Is there an annual QI work plan?
   - Does the QI program include objectives for culturally and linguistically diverse memberships?
   - Does the QI program include objectives for serving members with complex needs?

2. **Program Operations (QI 2)**
   - Does the QI committee meet regularly and take action on QI activities?
   - Is there documentation of QI committee meetings?
   - Are practitioners involved in the planning, design, implementation and review of the QI program?
   - Is the QI program information available to practitioners and members?

3. **Health Services Contracting (QI 3)**
   - Do participating practitioners and providers cooperate with QI activities, provide access to their medical records and protect the confidentiality of member information?
   - Do contracts with practitioners and providers ensure their free communication with patients about treatment?

4. **Availability of Practitioners (QI 4)**
   - Are plan practitioners located throughout the plan’s service area?
   - Did the plan consider the cultural needs of its members when it created its practitioner network? For example, are there multilingual practitioners?
• Does the plan take steps to ensure that there are sufficient numbers of primary care and specialty practitioners available to its members?
• Does the plan measure its performance and make improvements when needed?

5. Accessibility of Services (QI 5)
• Does the plan have standards to ensure access to medical care, including routine primary care, emergency care and after-hours care?
• Can members get behavioral health care when they need it?
• Does the plan measure its performance and make improvements when needed?

6. Member Satisfaction (QI 6)
• Does the plan evaluate member complaints and appeals?
• Does the plan analyze results of member satisfaction surveys and identify opportunities for improvement?
• Does the plan take steps to improve performance in these areas?

7. Complex Case Management (QI 7)
• Does the plan assess the characteristics and needs of its member population?
• Does the plan systematically identify members with complex conditions and refer them for case management?
• Are the plan's case management systems based on sound evidence?
• Does the plan have automated systems to support the case management staff?
• Do the plan's case management systems ensure appropriate documentation and follow-up?
• Do the plan's case management systems have processes for initial assessment and ongoing management of members?
• Does the plan measure its performance and member satisfaction, and take steps to improve performance when necessary?

8. Disease Management (QI 8)
• Does the plan offer programs and services to members with chronic health conditions?
• Does the plan systematically identify and inform members about its disease management programs?
• Does the plan measure member participation and program effectiveness?
• Does the plan inform and educate practitioners about these programs?
• Does the plan base interventions on stratification of severity or other clinical criteria?
• Does the plan integrate information from its systems and programs to facilitate continuity of care?

9. Clinical Practice Guidelines (QI 9)
• Does the plan establish practice guidelines for its practitioners?
• Is there a clinical basis to the guidelines?
• Are the guidelines reviewed at least every two years?
• Are the guidelines distributed to appropriate practitioners?
• Does the plan annually measure its performance against the guidelines?

10. Continuity and Coordination of Medical Care (QI 10)
• Does the plan identify improvement opportunities?
• Does the plan monitor the continuity and coordination of care between practitioners; for example, between a primary care physician and a specialist?
• Does the plan measure its performance and make improvements when needed?
• Does the plan or practitioner notify members affected by the termination of a primary care practitioner’s contract?
• Are there circumstances where members may continue to see a practitioner whose contract has been terminated?
11. Continuity and Coordination Between Medical and Behavioral Health Care (QI 11)

- Does the plan monitor the coordination of general medical care and behavioral health care?
- Does the plan collaborate with behavioral health specialists to collect and analyze data and implement improvement of coordination of behavioral health and general medical care?

12. Delegation of QI Activity (QI 12)

- If the plan delegates QI activities, does a delegation agreement outline responsibilities of the delegate and the plan, the delegated activities and the evaluation process?
- Does the plan evaluate the delegate on a regular basis?

Utilization Management (UM)

1. UM Structure (UM 1)

- Does the plan have a written description of its program for managing care?
- Is a senior physician involved in the program’s operation?
- Is a behavioral health practitioner involved in the behavioral health aspects of the program?
- Is the program evaluated, updated and approved annually?

2. Clinical Criteria for UM Decisions (UM 2)

- Are evidence-based clinical criteria and procedures for approving and denying care objective and based on clinical evidence?
- Do practitioners help develop criteria?
- Does the plan review and revise criteria annually?
- Can practitioners get a copy of the criteria if they ask for it?
- Does the plan evaluate how consistently criteria are applied?

3. Communication Services (UM 3)

- Is appropriate staff available to discuss UM issues with members and practitioners?
- Are there resources available for UM staff to communicate to members with special needs?

4. Appropriate Professionals (UM 4)

- Do qualified licensed health professionals oversee all medical necessity decisions?
- Does a licensed physician or other appropriate health care professional review denials of care based on medical necessity?
- Does the plan use board-certified consultants to assist in making medical necessity determinations?
- Does the plan ensure that no one involved in the decision-making process benefits from denying treatment to members?
- Does the plan notify members, health care professionals and staff that UM decisions are based on appropriateness of care and benefit coverage?

5. Timeliness of UM Decisions (UM 5)

- Does the plan use time frames specific to the clinical urgency of a situation when it makes coverage decisions?
- Does the plan notify members and practitioners about coverage decisions within required time frames?

6. Clinical Information (UM 6)

- Does the plan gather relevant clinical information and consult with the treating practitioner when it makes medical necessity determinations?
7. Denial Notices (UM 7)

- Does the plan have a documented process for onsite facility reviews, if applicable?
- Does the plan clearly document and communicate its reason(s) for denying a service?
- May practitioners discuss a medical necessity denial with the plan’s physician or a designated reviewer?
- Does the plan notify members and practitioners of the reason(s) for a denial in writing?
- Are appeal processes and rights outlined clearly in all denial notifications?

8. Policies for Appeals (UM 8)

- Does the plan have written policies and procedures for resolving member appeals?
- Does the plan have a process for responding to preservice, expedited, postservice, and external appeals?
- Do members have at least 180 days to appeal initial denial decisions?
- Does the plan give members access to all documents relevant to their appeal?
- May members submit comments, documents or other information relating to their appeal?
- Are appeal reviewers disinterested parties (i.e., not involved in the initial denial decision)?
- Are same-or-similar-specialty reviewers (i.e., practitioners in the same or a similar specialty who treat the condition under appeal) involved in appeals?
- Does the plan allow members’ authorized representatives to act on their behalf?
- Are members notified of additional appeal rights?

9. Appropriate Handling of Appeals (UM 9)

- Does the plan have a full and fair process for resolving member appeals, and does it follow its policies with regard to appeals?
- Does the plan document and investigate the substance of all appeals?
- Does the plan resolve appeals in a timely manner?
- Does the plan notify members in writing of appeal decisions, the reason(s) for the decision and their additional appeal rights?
- Does the plan ensure that overturned decisions are handled appropriately?

10. Evaluation of New Technology (UM 10)

- Does the plan have a written description of the process it uses to evaluate new technology for inclusion in its benefits plan?
- Does the plan implement new technology or new applications of existing technology based on its assessment and evaluation?

11. Satisfaction With the UM Process (UM 11)

- Does the plan evaluate member and practitioner satisfaction with its UM process, and does it act to improve areas of dissatisfaction?

12. Emergency Services (UM 12)

- Does the plan cover emergency services without precertification in cases where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed?
- Does the plan cover emergency services if an authorized agent of the plan approved their provision?

13. Procedures for Pharmaceutical Management (UM 13)

- Does the plan have clearly documented policies and procedures for drug coverage?
- If the plan restricts pharmacy benefits, does it have an exceptions policy?
- Do procedures cover patient safety issues?
• Are pharmaceutical management procedures reviewed and updated at least annually?
• Are pharmacists and appropriate practitioners involved in developing and updating procedures?
• Is there a clear process in place for applying procedures and ensuring that practitioners are aware of them?

14. Triage and Referral for Behavioral Health Care (UM 14)

• Does the plan assess and connect members to appropriate behavioral healthcare (BH) services in a timely manner based on the level of clinical urgency?
• Do licensed BH practitioners make all clinical triage and referral decisions?
• Is there appropriate clinical supervision and oversight of BH triage and referral decisions?

15. Delegation of UM (UM 15)

• If the plan delegates UM activities, does a delegation agreement outline responsibilities of the delegate and the plan, the delegated activities and the evaluation process?
• Did the plan evaluate the delegate before the agreement was signed?
• Does the plan annually approve the delegate’s UM program?
• Does the plan receive reports, evaluate delegate performance, and identify opportunities for improvement on a regular basis?

Credentialing and Recredentialing (CR)

1. Credentialing Policies (CR 1)

• Does the plan have clearly defined and documented procedures for assessing practitioner qualifications and practice history?
• Does the plan identify practitioner types that must be credentialed?
• Does the plan have policies and procedures that define a practitioner’s right to review and correct credentialing information?

2. Credentialing Committee (CR 2)

• Does the plan have a designated Credentialing Committee that reviews practitioner credentials and makes recommendations?

3. Initial Credentialing Verification (CR 3)

• Does the plan verify practitioner credentials, including a valid license to practice medicine, education and training, malpractice history and work history?

4. Application and Attestation (CR 4)

• Do practitioner applications include an attestation about limitations that would affect a practitioner’s performance; a history of loss of medical license and felony convictions; a history of limitation of privileges or disciplinary actions; and current malpractice insurance coverage?

5. Initial Sanction Information (CR 5)

• Does the plan review information (e.g., about disciplinary actions) from third parties?

6. Practitioner Office Site Quality (CR 6)
Does the plan set thresholds for office-site criteria and medical/treatment record-keeping practices?
Does the plan visit practice sites that reach its member complaint threshold?
Does the plan take necessary steps when an office does not meet its standards, and does it evaluate those steps regularly until the office improves?

7. **Recredentialing Verification (CR 7)**
   
   - Does the plan reevaluate practitioner qualifications?
   - Before reevaluating a practitioner's qualifications, does the plan receive information (e.g., about disciplinary actions) from third parties?

8. **Recredentialing Cycle Length (CR 8)**
   
   - Does the plan evaluate practitioner qualifications every 36 months?

9. **Ongoing Monitoring (CR9)**
   
   - Does the plan monitor practitioner sanctions, complaints and quality issues between the recredentialing cycles?
   - Does the plan take appropriate action when issues are identified?

10. **Notification to Authorities and Practitioner Appeal Rights (CR 10)**
    
    - Does the plan have a process for terminating the contracts of practitioners who demonstrate poor performance?
    - Does the plan have a process for practitioners to appeal a terminated contract?
    - Does the plan report to appropriate authorities when it suspends or terminates a practitioner's contract?

11. **Assessment of Organizational Providers (CR 11)**
    
    - Does the plan confirm that hospitals, home health care agencies, skilled nursing facilities, nursing homes and behavioral health facilities are in good standing with state and federal agencies and accrediting organizations?
    - Does the plan review the above standings at least every three years?

12. **Delegation of Credentialing (CR 12)**
    
    - If the plan delegates CR activities, does a delegation agreement outline responsibilities of the delegate and the plan, the delegated activities and the evaluation process?
    - Does the plan evaluate the delegate on a regular basis?

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**Members’ Rights and Responsibilities (RR)**

1. **Statement of Members’ Rights and Responsibilities (RR 1)**
   
   - Does the plan have a written members’ rights and responsibilities policy?
   - Does the policy state the plan’s expectations of members’ responsibilities?

2. **Distribution of Rights Statement to Members and Practitioners (RR 2)**
3. Policies for Complaints and Appeals (RR 3)

- Does the plan have written policies and procedures for the timely resolution of member complaints and appeals?
- Does the plan have written policies and procedures that include provisions for language services?

4. Subscriber Information (RR 4)

- Does the plan provide written information about benefits and charges for which members are responsible, including co-payments?
- Does the plan provide written information to members about how they can obtain care?
- Does the plan provide written information to members about how they can obtain language assistance?
- Does the plan provide written information to members about how they can file a complaint or appeal a decision about care?
- Does the organization provide interpreter or bilingual services for telephone functions based on the needs of its members?

5. Physician and Hospital Directories (RR 5)

- Does the plan provide a searchable Web-based directory of its physicians and hospitals?
- Does the physician and hospital directory contain the most current information?
- Does the plan test the directory for understanding and member ease of use?
- Is the directory available in other formats (e.g., printed, by telephone)?

6. Privacy and Confidentiality (RR 6)

- Does the plan take steps to protect the privacy of member information and records?
- Does the plan tell practitioners and current and potential members about these policies?

7. Marketing Information (RR 7)

- Do the plan’s marketing materials describe its procedures for approving or denying coverage; covered benefits, including pharmacy benefits; services that are not covered; practitioner and provider availability; and any applicable restrictions?
- Does the plan monitor new-member understanding of its procedures and update its marketing materials accordingly?

8. Delegation of Members’ Rights and Responsibilities (RR 8)

- If the plan delegates RR activities, does a delegation agreement outline responsibilities of the delegate and the plan, the delegated activities and the evaluation process?
- Does the plan evaluate the delegate on a regular basis?

Member Connections (MEM)

1. Health Appraisals (MEM 1)

- Does the plan provide a health appraisal that allows members to assess their risks of morbidity and mortality and identify how they can reduce risk?
- Does the plan disclose how information from the HA will be used, to whom it may be provided and for what purpose, and does the plan offer an opportunity for the member to consent or decline to have their information used or disclosed?
• Does the HA assess at least the 13 personal health characteristics and behaviors that are listed in the Standards and Guidelines?
• Does the plan provide HA results to the member such that the results are easy for the member to understand?
• Is the health appraisal available on the plan’s Web site, as well as in an alternative format (in print or by telephone)?
• Does the plan have the capability to administer the health appraisal annually?
• Is the health appraisal reviewed and updated at least every two years?

2. Self-Management Tools (MEM 2)

• Does the plan offer self-management tools in at least the following health areas: healthy weight (BMI) maintenance; smoking cessation; encouraging physical activity; healthy eating; managing stress; avoiding risky drinking; and identifying depressive symptoms?
• Are the self-management tools tested for their usefulness to members with consideration of language that is easy to understand and members’ special needs, including vision and hearing?
• Are the self-management tools reviewed and updated?
• Does the plan offer self-management tools online, in print and by telephone for each of the seven health areas?

3. Functionality of Claims Processing (MEM 3)

• Does the plan have a Web site and telephone services where members can obtain information about claims?
• Does the plan measure whether claims are handled in a timely and accurate way?

4. Pharmacy Benefit (MEM 4)

• Can members get information about their pharmacy benefits, their financial responsibility for medications and pharmacy operations on the Web and by telephone?
• Does the plan have a process to ensure that pharmacy information is accurate and current?

5. Personalized Information on Health Plan Services (MEM 5)

• Can members request or reorder an ID card or change a primary care practitioner on the plan’s Web site?
• Can members get information about referrals and services on the plan’s Web site or by telephone?
• Does the plan ensure the accuracy of the benefit information it communicates?
• Does the plan assess member satisfaction with its member materials and Customer Services telephone assistance?

6. Innovations in Member Service (MEM 6)

• Does the plan encourage the use of technology to improve services, convenience and appropriate use of health benefits?

7. Health Information Line (MEM 7)

• Can members access a health information line for answers to questions about their health?
• Is the health information line available by telephone 24 hours a day?
• Can health information line staff follow up on cases and link member contacts with a contact history?
• Does the plan track member use of its health information line?

8. Encouraging Wellness and Prevention (MEM 8)

• Does the plan identify members who are eligible for wellness programs?
• Does the plan provide follow-up based on member information?
Does the plan offer incentives to members to encourage them to stay healthy and prevent illness?

9. **Delegation of MEM (MEM 9)**

- If the plan delegates member connections activities, does a delegation agreement outline responsibilities of the delegate and the plan, the delegated activities and the evaluation process?
- Does the plan evaluate the delegate on a regular basis?

**Medicaid Benefits and Services (MED)**

1. **Medicaid Benefits and Services (MED 1)**

- Does the Medicaid plan provide direct access to women's health services?
- Does the Medicaid plan provide for a second opinion from an in-network provider or arranges for the member to obtain a second opinion outside the network?
- Does the Medicaid plan adequately cover services out-of-network when it cannot provide them within its network in a timely fashion?
- Does the Medicaid plan ensure that the cost to members for out-of-network services when it cannot provide them in its network is the same as the cost of in-network services?
- Does the Medicaid plan require the hours of operation that providers offer to Medicaid members to be no less than those offered to commercial members?

**HEDIS Measures Required for 2011 Accreditation**

**What performance measures must plans report?**

**2011 HEDIS Measures Required as Part of the NCQA Accreditation Process for Commercial Health Plans:**

- Antidepressant Medication Management
- Appropriate Treatment for Children With Upper Respiratory Infection
- Appropriate Testing for Children With Pharyngitis
- Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis
- Breast Cancer Screening
- Cervical Cancer Screening
- Childhood Immunization Status (Combination 2)
- Chlamydia Screening in Women (Total rate)
- Cholesterol Management for Patients With Cardiovascular Conditions (LDL-C Screening only)
- Colorectal Cancer Screening *
- Comprehensive Diabetes Care-Screening (Eye Examination, LDL-C Screening, HbA1c Testing, Medical Attention for Nephropathy)
- Comprehensive Diabetes Care - HbA1c Poorly Controlled (>9.0%)
- Controlling High Blood Pressure (Overall rate only)
- Flu Shots for Adults Ages 50-64
- Follow-Up After Hospitalization for Mental Illness (7-Day rate only)
- Follow-Up for Children Prescribed ADHD Medication (Initiation Phase, Continuation and Maintenance Phase) (Both rates)
- Medical Assistance With Smoking Cessation (Advising Smokers to Quit Only)
- Persistence of Beta-Blocker Treatment After a Heart Attack
- Prenatal and Postpartum Care (Timeliness of Prenatal Care and Postpartum Care)
- Use of Appropriate Medications for People With Asthma (Total rate)
- Use of Imaging Studies for Low Back Pain
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Claims Processing
- Customer Service
Getting Care Quickly
Getting Needed Care
How Well Doctors Communicate
Rating of All Health Care
Rating of Health Plan
Rating of Personal Doctor
Rating of Specialist Seen Most Often

*Indicates measure that does not apply to PPOs.

2011 HEDIS Measures Required as Part of the NCQA Accreditation Process for Medicare Health Plans

- Annual Monitoring for Patients on Persistent Medications (Total rate)
- Antidepressant Medication Management (Both rates)
- Breast Cancer Screening
- Cholesterol Management for Patients With Cardiovascular Conditions (LDL-C Screening only)
- Colorectal Cancer Screening*
- Comprehensive Diabetes Care (Eye Examination, LDL-C Screening, HbA1c Testing, Medical Attention for Nephropathy)
- Comprehensive Diabetes Care - HbA1c Poorly Controlled (>9.0%)
- Controlling High Blood Pressure
- Flu Shots for Older Adults
- Follow-Up After Hospitalization for Mental Illness (7-Day rate only)
- Glaucoma Screening in Older Adults
- Medical Assistance With Smoking Cessation (Advising Smokers to Quit Only)
- Osteoporosis Management in Women Who Had a Fracture
- Persistence of Beta-Blocker Treatment After a Heart Attack
- Pneumonia Vaccination Status for Older Adults
- Use of High-Risk Medications in the Elderly (Both rates)
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Getting Care Quickly
- Getting Needed Care
- How Well Doctors Communicate
- Rating of All Health Care
- Rating of Health Plan
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often

*Indicates measure that does not apply to PPOs.

2011 HEDIS Measures Required as Part of the NCQA Accreditation Process for Medicaid Health Plans

- Antidepressant Medication Management
- Appropriate Treatment for Children With Upper Respiratory Infection
- Appropriate Testing for Children With Pharyngitis
- Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis
- Breast Cancer Screening
- Cervical Cancer Screening
- Childhood Immunization Status (Combination 2)
- Chlamydia Screening in Women (Total rate)
- Cholesterol Management for Patients With Cardiovascular Conditions (LDL-C Screening only)
- Comprehensive Diabetes Care (Eye Examination, LDL-C Screening, HbA1c Testing, Medical Attention for Nephropathy)
- Controlling High Blood Pressure (Overall rate only)
- Follow-Up After Hospitalization for Mental Illness (7-Day rate only)
- Follow-Up for Children Prescribed ADHD Medication (Both rates)
- Comprehensive Diabetes Care - HbA1c Poorly Controlled (>9.0%)
- Medical Assistance With Smoking Cessation (Advising Smokers to Quit Only)
- Prenatal and Postpartum Care (Both rates)
- Use of Appropriate Medications for People With Asthma (Total rate)
- Use of Imaging Studies for Low Back Pain
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Customer Service
- Getting Care Quickly
- Getting Needed Care
- How Well Doctors Communicate
- Rating of All Health Care
- Rating of Health Plan
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often

*Indicates measure that does not apply to PPOs.