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\(^1\) All element numbers have been updated in accordance with the reorganized elements and standards. Please refer to Table 4 in the Health Plan Accreditation (HPA) 2020 Updates Overview for the full list of reorganized standard and elements.
QOG 1, Element A: QI Program Structure (formerly QI 1, Element A)

The organization's QI program description specifies:

1. The QI program structure.
2. The behavioral healthcare aspects of the program.
3. Involvement of a designated physician in the QI program.
4. Involvement of a behavioral healthcare practitioner in the behavioral aspects of the program.
5. Oversight of QI functions of the organization by the QI Committee.
6. An annual work plan.* [Moved to a separate element]
6. Objectives for serving a culturally and linguistically diverse membership.

*Critical factors: Score cannot exceed 20% if critical factors are not met.

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Data source: Documented process, Reports

Scope of review: This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For Interim Surveys and First Surveys: NCQA reviews the organization’s QI program description that is in place throughout the look-back period and the annual work plan.

For Renewal Surveys: NCQA reviews the organization’s QI program description that is in place throughout the look-back period and the most recent and the previous year’s annual work plans.

Look-back period:
For Interim Surveys: Prior to the survey date.
For First Surveys: 6 months.
For Renewal Surveys: 24 months.

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

Factor 6 is a critical factor that the organization must meet to score higher than 20% on this element.
The QI program description

The QI program description is a comprehensive document or a set of documents that describes, in plain language, the QI program’s governance, scope, goals, measurable objectives, structure and responsibilities and annual work plan.

**Factor 1: Program structure**

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

- The QI program’s functional areas and their responsibilities.
- Reporting relationships of QI Department staff and the QI Committee.
- Resources and analytical support.
- Delegated QI activities, if the organization delegates QI activities.
- Collaborative QI activities, if any.
- How the QI and population health management programs are related in terms of workstreams and oversight.

**Factor 2: Behavioral healthcare**

The program description outlines the organization’s efforts to monitor and improve behavioral healthcare.

**Factor 3: Involvement of designated physician**

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

The physician may be a medical director, associate medical director or other physician assigned this task.

**Factor 4: Involvement of designated behavioral healthcare practitioner**

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

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

**Factor 5: QI Committee oversight**

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

- If participating practitioners are not members of the QI committee, they are involved in a clinical subcommittee or relevant ad hoc task forces.
- If organization staff are not members of the QI committee, they are involved in multidisciplinary work groups or subcommittees.

**Factor 6: Annual work plan**

The program description includes a work plan that reflects ongoing progress on QI activities throughout the year and addresses:

- Yearly planned QI activities and objectives for improving: 
Quality of clinical care.
Safety of clinical care.
Quality of service.
Members’ experience.
- Time frame for each activity’s completion.
- Staff members responsible for each activity.
- Monitoring of previously identified issues.
- Evaluation of the QI program.

The work plan is a dynamic document. All bulleted requirements must be described for factor 6 to be scored “Yes.”

Factor 7: Serving a diverse membership

The program description outlines the organization’s approach to address the cultural and linguistic needs of its membership. The QI program description might include objectives or other objectives the organization deems appropriate:

- To reduce health care disparities in clinical areas.
- To improve cultural competency in materials and communications.
- To improve network adequacy to meet the needs of underserved groups.
- To improve other areas of needs the organization deems appropriate.

Exceptions

Factors 2 and 4 are NA if all purchasers of the organization’s services carve out behavioral healthcare services (i.e., contract for a service or function to be performed by an entity other than the organization).

Related information

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

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

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

Examples  Factor 7: Objectives for serving diverse membership

- Analyze significant health care disparities in clinical areas.
- Use practitioner and provider chart reviews and interviews to understand the differences in care provided and outcomes achieved.
- Conduct patient-focused interventions with culturally competent outreach materials that focus on risks specific to race/ethnicity/language.
- Conduct focus groups or key informant interviews with cultural or linguistic minority member to determine how to meet their needs.
- Identify and reduce a specific health care disparity.
- Provide information, training and tools to staff and practitioners to support culturally competent communication.
QOG 1, Element B: Annual Work Plan (formerly QI 1, Element A, factor 6)

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

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

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Data source: Reports

Scope of review: This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For Interim Surveys, First Surveys: NCQA reviews the organization’s QI program annual work plan.

For Renewal Surveys: NCQA reviews the organization’s most recent and the previous year’s annual work plans.

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

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation: The work plan is a dynamic document, which needs to have a full year of planned activities and objectives.

Factor 1: Yearly planned QI activities and objectives
There must be activities that address each of these areas:

- Quality of clinical care.
- Safety of clinical care.
- Quality of service.
- Members’ experience.

These must be identified by the organization; it is not up to NCQA to determine which activities meet the four categories.

Factor 2. Time frame for each activity’s completion.
For each activity, a timeframe for completion must be included. Timeframes must be specific and stated with a date, month or quarter, as opposed to with a frequency.

Factor 3. Staff members responsible for each activity.
Staff responsible for each activity must be listed. This may be by title or role; it does not require a name. This may be the lead staff person(s); the organization is not required to list all staff involved in the activity.

Factor 4. Monitoring of previously identified issues.
The QI workplan identifies measurement and analysis activities that monitor activities that are previously identified. These may be activities that have multiple cycles of measurement.

Factor 5. Evaluation of the QI program.

Annual evaluation of the QI program must be a specific activity on the work plan, with a stated timeframe and the staff responsible.

**ME 7, Element A: Policies and Procedures for Complaints (formerly RR 2, Element A)**

The organization has policies and procedures for registering and responding to oral and written complaints that include:

1. Documentation of the substance of complaints and actions taken.
2. Investigation of the substance of complaints, including any aspect of clinical care involved.
3. Notification to members of the disposition of complaints and the right to appeal, as appropriate.
4. Standards for timeliness that take urgency into account, including standards for clinically urgent situations.
5. Provision of language services for the complaint process.

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**Scoring**

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

**Data source**

Documented process

**Scope of review**

*This element applies to Interim Surveys, First Surveys and Renewal Surveys.*

NCQA reviews the organization’s policies and procedures.

**Look-back period**

*For Interim Surveys*: Prior to the survey date.
*For First Surveys*: 6 months.
*For Renewal Surveys*: 24 months.

**Explanation**

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

**Factor 1: Documentation**

No additional explanation required.

**Factor 2: Investigation**
The organization researches and documents issues relevant to the complaint. The organization’s policies and procedures for resolving quality-of-care complaints specify when practitioner review is required.

**Factor 3: Notification of resolution and appeal rights**

Members have the right to appeal an adverse decision. If the organization makes an adverse decision, it notifies members of the decision and of their right to appeal.

If the organization cannot resolve a complaint within the time frame stated in its policies or cannot notify the member of the final decision for legal or statutory reasons, at a minimum, it must notify the member that the complaint was received and investigated.

**Factor 4: Timeliness**

The organization sets standards for timeliness of registering and responding to complaints. The organization’s timeliness and notification standards consider clinical urgency.

**Factor 5: Language services**

The organization provides language services through bilingual staff or interpreter services to help members through the complaint process.

Use of contracted translation services is not considered delegation.

**Exceptions**

None.

**Examples**  

**Factor 5: Language services**

- Oral interpretation of documents written in English into a member’s preferred language.
- Member notification documents are available in languages other than English.
- Language-line interpretation services are available for registering oral complaints.

---

**ME 7, Element B: Policies and Procedures for Appeals (formerly RR 2, Element B)**

The organization has policies and procedures for registering and responding to oral and written appeals *of decisions that are not about coverage* that include:

1. Documentation of the substance of appeals and actions taken.
2. Investigation of the substance of appeals *including any aspect of clinical care involved*.
3. Notification to members of the disposition of appeals and the right to further appeal, as appropriate.
4. Standards for timeliness *that take urgency into account*, including standards for clinically urgent situations.
5. Provision of language services for the appeal process.

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Appendix 2: HPA 2020 Marked-Up Standards

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Data source
Documented process

Scope of review
This element applies to Interim Surveys, First Surveys and Renewal Surveys.
NCQA reviews the organization’s policies and procedures.

Look-back period
For Interim Surveys: Prior to the survey date.
For First Surveys: 6 months.
For Renewal Surveys: 24 months.

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

“Appeal” in this element refers to appeals of decisions that are not about coverage. Appeals for coverage are assessed in UM 8: Policies for Appeals and UM 9: Appropriate Handling for Appeals. Members or their authorized representatives may appeal any adverse decision.

Factor 1: Documentation
No additional explanation required.

Factor 2: Investigation
The organization researches and documents issues relevant to the appeal.

Factor 3: Notification of resolution and appeal rights
The organization notifies members of its decision and of their right to appeal the resolution further within the time frame specified in its policies.

Factor 4: Timeliness
The organization’s timeliness and notification standards appeals consider clinical urgency.

Factor 5: Language services
The organization provides language services through bilingual staff or interpreter services to help members through the appeal process.
Use of contracted translation services is not considered delegation.

Exceptions
None.

Examples
Appeals of decisions that are not about coverage:
- Payment
- Eligibility
- Enrollment
• Subsidy-Level (marketplace)
• Exemptions from purchasing HI (marketplace)
• Provider Contracts
• Quality or Delivery of Service
• Service Level from plan
• Rescission of Coverage
• Primary care practitioner change requests

Factor 5: Language services
• Oral interpretation of documents that are written in English into a member’s preferred language.
• Member notification documents are available in languages other than English.
• Language-line interpretation services are available for registering oral appeals.

ME 7, Element C: Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals (formerly QI 4, Element C)

Using valid methodology, the organization annually evaluates nonbehavioral complaints and appeals for each of the five required categories.

To assess member experience with its services, the organization annually evaluates member complaints and appeals using the following methods:

1. Collects valid measurement data for each of the five required categories.
2. Analyzes data.

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Data source
Reports

Scope of review
This element applies to First Surveys and Renewal Surveys.
NCQA reviews this element for each product line brought forward for accreditation.
For First Surveys: NCQA reviews the organization’s most recent annual data collection and evaluation report.
For Renewal Surveys: NCQA reviews the organization’s most recent and the previous year’s annual data collection and evaluation report.
The score for the element is the average of the scores for all product lines.
Look-back period

For First Surveys: At least once during the prior year.
For Renewal Surveys: 24 months.

Explanation

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

**Factor 1: Data collection and grouping**

The organization collects data from all sources of members’ complaints and from coverage and non-coverage appeals. The organization aggregates all complaints and appeals them into the following required categories:

- Quality of Care.
- Access.
- Attitude and Service.
- Billing and Financial Issues.
- Quality of Practitioner Office Site.

Collected data include UM coverage appeals addressed in *UM 8: Policies for Appeals* and UM 9: Appropriate Handling of Appeals, and noncoverage appeals addressed in *RR 2: Policies and Procedures for Complaints and Appeals*.

*Note*: Data collected and analyzed prior to December 15, 2017, will be accepted as meeting the requirement, even if not all types of appeals are included. Data collected and analyzed on or after this date must comply with the requirement.

The organization may use a different coding system for internal purposes, but it must aggregate and analyze all complaint and appeal data in the reporting categories above for NCQA evaluation purposes.

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

The organization may assess the entire population or draw statistically valid samples. If the organization uses a sample, it describes the sample universe and the sampling methodology.

**Factor 2: Analysis of data**

The organization completes a quantitative and qualitative analysis of the data collected.

 Exceptions

This element is NA for the Marketplace 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 which was denied. The member appealed the decision.
• Citing a shortage of Spanish-speaking practitioners, a member requested to go out of network. The request was denied and the member appealed the decision.

• A member 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 the practitioner was rude and used abusive language.

• A member complained that there was a 30-minute wait to checkout after an appointment.

**Billing/Financial**

• Out-of-network services where members are balance billed.

• Disputes of deductibles and copayments.

**Quality of Practitioner Office Site**

• A member sought out-of-network care because the participating practitioner’s offices lacked wheelchair accessibility. The organization identified other practitioners with wheelchair access but the member appealed to go out of network.

---

**Table 1: Complaint volume report**

<table>
<thead>
<tr>
<th>Category</th>
<th>Previous Year Complaints, Total</th>
<th>Previous Year Complaints per 1,000 Members (Total Members 300,000)</th>
<th>Current Measurement Year Complaints, Total</th>
<th>Current Measurement Year Complaints per 1,000 Members (Total Members 240,000)</th>
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<tr>
<td>Quality of Care</td>
<td>1,462</td>
<td>4.87</td>
<td>1,323</td>
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<td>3.15</td>
<td>951</td>
<td>3.96</td>
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<td>Billing/Financial</td>
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<td>2.72</td>
<td>785</td>
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<td>Quality of Practitioner Office Site</td>
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<td>1.44</td>
<td>413</td>
<td>1.72</td>
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<tr>
<td>Total/Number per 1,000</td>
<td>4,731</td>
<td>15.77</td>
<td>4,888</td>
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**Table 2: Appeal volume report**

<table>
<thead>
<tr>
<th>Category</th>
<th>Previous Year Appeals, Total</th>
<th>Previous Year Appeals per 1,000 Members</th>
<th>Current Measurement</th>
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Appendix 2: HPA 2020 Marked-Up Standards

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<th>Total Members (300,000)</th>
<th>Year Appeals, Total</th>
<th>1,000 Members (Total Members 240,000)</th>
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<tr>
<td>Access</td>
<td>121</td>
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<tr>
<td>Attitude/Service</td>
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<tr>
<td>Billing/Financial</td>
<td>91</td>
<td>0.30</td>
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<tr>
<td>Quality of Practitioner Office Site</td>
<td>68</td>
<td>0.23</td>
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<tr>
<td>Total/Average</td>
<td>566</td>
<td>1.89</td>
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</table>

3. Analyze Member Services staffing needs and increase staff, if appropriate.
4. Train Member Services staff in communication skills.
5. Recruit Spanish- and Chinese-speaking Member Services staff.
6. Develop and implement a program to help practitioners communicate with non-English-speaking patients.

**ME 7, Element E: Annual Assessment of Behavioral Healthcare and Services (formerly QI 4, Element E)**

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.

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**Data source** Reports

**Scope of review**

*This element applies to First Surveys and Renewal Surveys.*

NCQA reviews this element for each product line brought forward for accreditation.
**Look-back period**

*For First Surveys:* At least once during the prior year.
*For Renewal Surveys:* 24 months.

**Explanation**

The organization evaluates member complaints and appeals from the entire population of members who have used behavioral healthcare services, or draws a statistically valid sample from that population of members. If the organization uses a member sample, it describes the sample universe and the sampling methodology.

**Factor 1: Member complaints and appeals**

The organization collects data from all sources of members’ complaints and from coverage and non-coverage appeals. The organization aggregates all complaints and appeals them into the following categories:

- Quality of Care.
- Access.
- Attitude and Service.
- Billing and Financial Issues.
- Quality of Practitioner Office Site.

This includes UM coverage appeals addressed in UM 8: Policies for Appeals and UM 9: Appropriate Handling of Appeals, and noncoverage appeals addressed in RR 2: Policies and Procedures for Complaints and Appeals.

**Note:** Data collected and analyzed prior to December 15, 2017, will be accepted as meeting the requirement, even if not all types of appeals are included. Data collected and analyzed on or after this date must comply with the requirement.

The organization may use a different coding system for internal purposes, but it must aggregate and analyze all complaint and appeal data in the reporting categories above for NCQA evaluation purposes.

The organization reports 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 5.0H survey does not meet this factor; however, supplemental questions to the survey regarding behavioral healthcare may meet this factor if the organization...
has added a supplemental screening question to identify members who have accessed behavioral healthcare services.

**Exception**

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

**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.
- Inadequate seating in the waiting room.
- The treatment setting is not safe.
NET 3, Element A: Assessment of Member Experience Accessing the Network

The organization annually identifies gaps in networks specific to geographic areas or types of practitioners or providers by:

1. Using analysis results related to member experience with network adequacy for nonbehavioral healthcare services from QI 4, Element C and Element D.
2. Using analysis results related to member experience with network adequacy for behavioral healthcare services from QI 4, Element F.
3. Compiling and analyzing nonbehavioral requests for and utilization of out-of-network services.
4. Compiling and analyzing behavioral healthcare requests for, and utilization of, out-of-network services.

The organization annually:

1. Analyzes data from member experience, complaints and appeals about network adequacy for nonbehavioral healthcare services from QI 4, Element C and Element D.
2. Analyzes data from member experience, complaints and appeals about network adequacy for behavioral healthcare services from QI 4, Element E.
3. Compiles and analyzes requests for and utilization of out-of-network services.
4. Uses analyses from factors 1-3 to determine if there are gaps in the network specific to particular geographic areas or types of practitioners or providers.

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### Data source

Reports

### Scope of review

This element applies to First Surveys and Renewal Surveys for commercial, Medicare and Medicaid product lines only.

For First Surveys, NCQA reviews the organization’s most recent completed report. For Renewal Surveys, NCQA reviews the organization’s most recent and previous year’s completed reports. For factor 3, NCQA reviews the organization’s most recent annual report.

NCQA reviews this element for each product line brought forward for accreditation.

### Look-back period

For First Surveys: At least once during the prior year.
For Renewal Surveys: 24 months for factors 1, 2 and 4; at least once during the prior year for factor 3.

The organization’s analysis report indicates whether complaints, appeals and out-of-network requests and utilization data are specific to particular geographic areas or types of practitioners or providers.

**Factors 1, 2: Analysis of data from member experience, complaints and appeals**

The organization completes a quantitative and qualitative analysis, by product/product line, of member complaint and appeal data related to network adequacy (e.g., requests for out-of-network services, appeals, complaints specific to access) and member experience (CAHPS or member experience survey).

Analysis of complaints, appeals and experience related to network adequacy may be included in the overall analysis of member experience for QI 4, Elements C-E. However, the documentation must clearly reflect the results/analysis/opportunities by product line as evidence to meet this element.

**Factor 3-4: Requests for and utilization of out-of-network services**

The organization compiles data on member requests for out-of-network services and data on actual out-of-network utilization to identify and monitor issues with access to primary care services, behavioral healthcare services and other specialty services, practitioners and providers. The organization reports data per thousand members at the product line-level.

The organization conducts qualitative and quantitative analysis to identify possible causes of out-of-network requests and utilization and opportunities to improve network adequacy.

**Factor 4: Analysis of complaints and out-of-network data specific to geographic area or types of practitioners**

**Exceptions**

This element is NA for the Marketplace product line.

Factor 2 is NA if all purchasers of the organization’s services carve out or exclude behavioral healthcare.

For First Surveys: Organizations are not required to include CAHPS in their analysis reports. However, an organization that wants to be eligible for Commendable or Excellent accreditation status may opt to submit HEDIS/CAHPS results; optional CAHPS results are included in the analysis for factor 1.

**Examples**

**Factor 3: Requests for and utilization of out-of-network services**

**UM reports**

- Member/practitioner requests for out-of-network services, including:
  - Urgent concurrent, urgent preservice, nonurgent preservice and post-service requests.
  - Final determinations resulting from these requests (approvals and denials, regardless of reason code).
- For PPO products, organizations may compile and analyze requests and final determinations for in-network level of benefit coverage.

**Claims data**
• Claims denied with the reason “services available in network” or other out-of-network indicator.

• For PPO products, organizations may compile and analyze claims paid with out-of-network cost sharing applied or at price tiers higher than the lowest cost-sharing level.

**Factors 3, 4**

Results of the organization’s analysis of requests for out-of-network services and actual utilization of out-of-network services showed that in the previous 12 months, 600 member requests for out-of-network services were processed through utilization management and 60 requests were processed through appeals. Most out-of-network activity was in an HMO plan, which represented 80 percent of all UM decisions and appeals. Most requests were approved, which indicates that there is a process in place to accommodate members in areas where the network lacks practitioners.

The organization is aware that there are various reasons why members might be requesting or obtaining out-of-network services, including lack or limited number of practitioners (e.g., subspecialists) in a geographic area; lack of member understanding about covered benefits and the referral process; primary care referral to an out-of-network specialist; services received by an out-of-network practitioner in a network hospital; physician and hospital directory inaccuracies; personal preference. Detailed analysis of denied requests showed that members in Southern California accessed out-of-network cardiologists and podiatrists most frequently.

**NET 3, Element B: Opportunities to Improve Access to Nonbehavioral Healthcare Services**

The organization annually:

1. Prioritizes opportunities for improvement identified from analyses of availability (NET 1), accessibility (NET 2) and member experience accessing the network (NET 3, Element A) CAHPS survey results and member complaints and appeals (NET 3, Element A, factor 1) and out-of-network services data (NET 3, Element A, factor 3).

2. Implements interventions on at least one opportunity, if applicable.

3. Measures the effectiveness of interventions, if applicable.

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

© 2018 National Committee for Quality Assurance  
Obsolete After December 17, 2018
Scope of review

This element applies to First Surveys and Renewal Surveys for commercial, Medicare and Medicaid products only.

For First Surveys: NCQA reviews the organization’s most recently completed report.

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

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

For Renewal Surveys: during the most recent year of the look-back period, the organization prioritized opportunities for all aspects in factor 1.

For Renewal Surveys: during the previous year of the look-back period, the organization prioritized opportunities for availability, accessibility, CAHPS survey results and member complaints and appeals.

NCQA reviews this element for each product line brought forward for accreditation.

Look-back period

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

For Renewal Surveys: 24 months; at least once during the prior year for the “out-of-network services” data component of factor 1.

Explanation

Factors 1–3

The organization summarizes opportunities identified from analyses of nonbehavioral healthcare data from NET 3, Element A, factors 1 and 3 to show a comprehensive overview of network access issues. Data may be reported individually, but must be evaluated collectively in a single, comprehensive analysis to meet this element. The organization prioritizes opportunities by importance to member need and risk to member access to nonbehavioral healthcare services.

Exceptions

This element is NA for the Marketplace product line.

For First Surveys: Organizations are not required to include CAHPS in their analysis reports. However, an organization that wants to be eligible for Commendable or Excellent accreditation status may opt to submit HEDIS/CAHPS results; optional CAHPS results are included in the analysis for this element.

Factor 3 is NA for First Surveys.

Examples

None.

NET 3, Element C: Opportunities to Improve Access to Behavioral Healthcare Services

The organization annually:

1. Prioritizes improvement opportunities identified from analyses of availability (NET 1), accessibility (NET 2) and member experience accessing the network (NET 3, Element A), complaints and appeals or member experience (NET 3, Element A, factor 2) and out-of-network services data (NET 3, Element A, factor 3).

2. Implements interventions on at least one opportunity, if applicable.
3. Measures the effectiveness of the interventions, if applicable.

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Data source: Documented process, Reports, Materials

Scope of review: This element applies to First Surveys and Renewal Surveys for commercial, Medicare and Medicaid products only.

For First Surveys: NCQA reviews the organization’s most recently completed report.

For Renewal Surveys: NCQA reviews the organization’s most recent and previous year’s completed report.

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

For Renewal Surveys: During the most recent year of the look-back period, the organization prioritized opportunities for all aspects in factor 1.

For Renewal Surveys: During the previous year of the look-back period, the organization prioritized opportunities for availability, accessibility, complaints and appeals and member experience.

NCQA reviews this element for each product line brought forward for accreditation.

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

For Renewal Surveys: 24 months; at least once during the prior year for the “out-of-network services” data component of factor 1.

Explanation: Factors 1–3

The organization summarizes opportunities identified from analyses of behavioral healthcare data from NET 3, Element A, factors 2 and 3 to show a comprehensive overview of network access issues. Data may be reported individually, but must be evaluated collectively in a single, comprehensive analysis to meet this element. The organization prioritizes opportunities by importance to member need and risk to member access to nonbehavioral healthcare services.

Exceptions: This element is NA:

- If all purchasers of the organization’s services carve out or exclude behavioral healthcare.
• For the Marketplace product line.

Factor 3 is NA for First Surveys.

Examples

None.
QOG 3, Element A: Written Program Description (formerly UM 1, Element A)

The organization's UM program description includes the following:

1. A written description of the program structure.
2. The behavioral healthcare aspects of the program.
3. Involvement of a designated senior-level physician in UM program implementation.
4. Involvement of a designated behavioral healthcare practitioner in the implementation of the behavioral healthcare aspects of the UM program.
5. The program scope and process used to determine benefit coverage and medical necessity.
6. Information sources used to determine benefit coverage and medical necessity.

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Data source: Documented process, Reports

Scope of review:

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

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

For First and Renewal Surveys: NCQA reviews the organization’s:

- UM program description and

For factors 3 and 4, UM Committee minutes or other reports that document active involvement of a senior-level physician and a designated behavioral healthcare practitioner in the UM program 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 is a structural requirement. The organization must present its own documentation.

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

Medical necessity review:

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

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

Decisions about the following require medical necessity review:

- Covered medical benefits defined by the organization’s Certificate of Coverage or Summary of Benefits.
- Preexisting conditions, when the member has creditable coverage and the organization has a policy to deny preexisting care or services.
- Care or services whose coverage depends on specific circumstances.
- Dental surgical procedures that occur within or adjacent to the oral cavity or sinuses and are covered under the member’s medical benefits.
- Out-of-network services that are only covered in clinically appropriate situations.
- Prior authorizations for pharmaceuticals and pharmaceutical requests requiring prerequisite drug for a step therapy program.
- “Experimental” or “investigational” requests, unless the organization’s policies specifically exclude the requested services or procedures from the benefits plan and deem them never medically necessary under any circumstances. In this case, medical necessity review is not required.

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 that does not depend on any circumstances.
- Requests for personal care services, such as cooking, grooming, transportation, cleaning and assistance with other ADL-related activities.

If the services above, which do not require medical necessity review, are covered benefits and are denied and subsequently appealed, they are within the scope of UM 8 and UM 9.

**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.

The scope of medical necessity review
All denials resulting from medical necessity review as defined above are within the scope of review for the applicable elements in UM 4–UM 7, regardless of whether or not the member is 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 for 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.

**Factor 1: Program structure**

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

- UM staff’s assigned activities.
- UM staff who have 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 the triage and referral process for behavioral healthcare services, how the organization evaluates service sites and the levels of behavioral healthcare services.

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

The program description specifies how a senior-level physician, who is a medical director, associate medical director or equivalent, is involved in UM activities, including implementation, supervision, oversight and evaluation of the UM program.

*For First and Renewal Surveys, UM Committee minutes or other reports demonstrate the involvement of a senior-level physician in the activities as indicated in the program description.*

**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 involved 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).

For First and Renewal Surveys, UM Committee minutes or other reports demonstrate the involvement of a designated behavioral healthcare practitioner in UM activities as indicated in the program description.

Factors 5, 6: Processes and information sources used to make determinations

The program description specifies:

- The UM functions, the services covered by each function or protocol and the criteria used to determine medical necessity, including:
  - How the organization develops and selects criteria.
  - How the organization reviews, updates and modifies criteria.
- How medical necessity and benefits coverage for inpatient and outpatient services are determined.
- The 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.

Exception

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

Related information

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

Examples  Factor 3: Senior-level physician involvement

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

- Setting UM policies.
- Supervising program operations.
- Reviewing UM cases.
- Participating on the UM Committee.
- Evaluating the overall effectiveness of the UM program.
**Factor 4: Behavioral healthcare practitioner involvement**

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

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

**QOG 3, Element C: Policies for UM Criteria (formerly UM 2, Element A, factors 1-3)**

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. [moving to a separate element]
5. Annually reviews the UM criteria and the procedures for applying them, and updates the criteria when appropriate. [moving to a separate element]

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**Data source**

Documented process, Reports, Materials

**Scope of review**

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

*For Interim Surveys*: NCQA reviews the organization’s policies and procedures for factors 1-3.

*For First Surveys and Renewal Surveys*: NCQA reviews the following:

- For factors 1–3: Policies and procedures in place throughout the look-back period.
- For factor 4: Meeting minutes or other reports documenting the involvement of appropriate practitioners throughout the look-back period.
- 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 evaluate the necessity 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 individual characteristics when applying criteria:

- 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 have the opportunity to advise or comment on development or adoption of UM criteria, and on instructions for applying criteria. Practitioners may be on staff of participants in the network. 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, a designated group may determine if further review of a criterion is necessary.

Exception

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

Related information

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

Examples

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

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

- Availability of inpatient outpatient and transitional facilities.
- Availability of outpatient services in lieu of inpatient services such as surgicenters 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.

QOG 3, Element D: UM Criteria Maintenance (formerly UM 2, Element A, factors 4-5)

The organization:

1. **Involves appropriate practitioners in developing, adopting and reviewing criteria.**
2. **Annually reviews the UM criteria and the procedures for applying them, and updates the criteria when appropriate.**

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**Data source** Reports, Materials
**Scope of review**

This element applies to First Surveys and Renewal Surveys.

- For factor 1, NCQA reviews meeting minutes or other reports documenting the involvement of appropriate practitioners throughout the look-back period.
- For factor 2, NCQA reviews 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 First Surveys: 6 months for factor 1; 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: Practitioner involvement**

Practitioners with clinical expertise in the area being reviewed have the opportunity to advise or comment on development or adoption of UM criteria, and on instructions for applying criteria. Practitioners may be on staff of participants in the network. The organization may have practitioners review criteria if it does not develop its own UM criteria and obtains criteria from external entities.

**Factor 2: 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, a designated group may determine if further review of a criterion is necessary.

**Exception**

Factor 2 is NA for UM criteria in use for less than 12 months.

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**ME 1, Element A: Rights and Responsibilities Statement (formerly RR 1, Element A)**

The organization distributes a member rights and responsibilities statement that includes the following information members have:

1. A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
2. A right to be treated with respect and recognition of their dignity and their right to privacy.
3. A right to participate with practitioners in making decisions about their health care.
4. A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
5. A right to voice complaints or appeals about the organization or the care it provides.
6. A right to make recommendations regarding the organization’s member rights and responsibilities policy.
7. A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.

8. A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.

9. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

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Materials, Reports

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For Interim Surveys: NCQA reviews information that will be sent to members and practitioners.

For First Surveys and Renewal Surveys, NCQA reviews:

- The organization’s rights and responsibilities statement that is in place throughout the look-back period
- Evidence that the organization sent the information to members and practitioners.

Look-back period

NCQA reviews the organization’s rights and responsibilities statement that is in place throughout the look-back period.

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

Authority for this activity may not be delegated and must be performed by the organization.

The organization notifies members and practitioners of policy revisions as they occur.

Distribution of rights statement

The organization distributes information to new members upon enrollment and to new practitioners when they join the network by mail, fax, or email.

The organization makes the information available upon request for existing members and practitioners.
The organization may include the statement on its website if it informs members and practitioners that the information is available online. The organization also informs members and practitioners that the statement is available through alternative media upon request.

The organization mails the information to members and practitioners who do not have fax, email or internet access.

**Factors 1–9**

No additional explanation required.

**Exceptions**

None.

**Examples**

None.

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**ME 2, Element A: Subscriber Information (formerly RR 3, Element A)**

The organization distributes the following written information to its subscribers upon enrollment and annually thereafter:

1. Benefits and services included in, and excluded from, coverage.

2. Pharmaceutical management procedures, if they exist.

3. Copayments and other charges for which members are responsible.

4. Benefit restrictions that apply to services obtained outside the organization's system or service area.

5. How to obtain language assistance.

6. How to submit a claim for covered services, if applicable.

7. How to obtain information about practitioners who participate in the organization.

8. How to obtain primary care services, including points of access.

9. How to obtain specialty care and behavioral healthcare services and hospital services.

10. How to obtain care after normal business hours.

11. How to obtain emergency care, including the organization’s policy on when to directly access emergency care or use 911 services.

12. How to obtain care and coverage when subscribers are out of the organization’s service area.

13. How to submit a complaint.

14. How to appeal a decision that adversely affects coverage, benefits or a subscriber’s relationship with the organization.

15. Availability of independent, external review of final internal UM determinations (former UM 8B: Notice of External Review Rights)
16. How the organization evaluates new technology for inclusion as a covered benefit.

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<td>The organization meets 12-16 factors</td>
<td>The organization meets 8-11 factors</td>
<td>The organization meets 0-7 factors</td>
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This element applies to Interim Surveys, First Surveys and Renewal Surveys.

NCQA reviews this element for each product line brought forward for accreditation.

For Interim Surveys: NCQA reviews information that will be sent to subscribers.

For First Surveys and Renewal Surveys, NCQA reviews:

- Organization’s materials containing subscriber information distributed to subscribers and evidence that the organization sent the information to subscribers.

The score for the element is the average of the scores for all product lines.

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.

For First Surveys and Renewal Surveys, NCQA does not accept or review materials presented in draft form or not yet distributed.

Information about subscriber benefits and services can be accessed easily and is written in user-friendly language.

Distribution of subscriber information

The organization distributes information to members and practitioners by mail, fax, email.

The organization may include the statement on its website if it informs members and practitioners that the information is available online. The organization also informs members and practitioners that the statement is available through alternative media upon request.

The organization distributes information to subscribers by mail, fax or email, or on its website, if it informs subscribers that the information is available online. The organization mails the information to subscribers who do not have fax, email or internet access.
Factor 1: Benefits and services

No additional explanation required.

Factor 2: Pharmaceutical management

Information distributed to subscribers includes a description of the following components of the organization's pharmaceutical management policies and procedures:

- Procedures that affect coverage of pharmaceuticals.
- How to obtain or review lists of pharmaceuticals.
- How to obtain or review limitations on prescribing or on access to pharmaceuticals.
- The copayment structure for restricted pharmaceuticals.
- The exceptions policy for coverage of nonformulary pharmaceuticals (if there is a closed formulary).

Factors 3, 4

No additional explanation required.

Factor 5: Language assistance

The organization provides language services to all subscribers who request them, through bilingual staff or interpreter services, to help subscribers obtain information about benefits and access to medical services.

Use of contracted translation services is not considered delegation.

Factor 6: Claims for covered services

No additional explanation required.

Factor 7: Information about practitioners

The organization tells subscribers how to obtain the following practitioner information:

- Name, address, telephone numbers.
- Professional qualifications.
- Specialty.
- Medical school attended.
- Residency completion.
- Board certification status.

Factor 8: Primary care services

No additional explanation required.

Factor 9: Specialty care, behavioral healthcare and hospital services

If the organization uses a primary care gatekeeper system, it tells subscribers how to access specialists through primary care practitioners. If the organization allows self-referrals for specialist services, such as behavioral healthcare or cardiology, it tells subscribers how to access these services.
The organization tells subscribers if they are restricted from certain specialists in its network.

The organization tells subscribers how to access hospital services.

*Factors 10, 11*

No additional explanation required.

*Factor 12: Care and coverage outside the service area*

The organization tells subscribers how to access services outside the service area, including information on covered and noncovered benefits.

*Factor 13: Submitting a complaint*

The organization informs subscribers how to submit complaints both orally and in writing.

*Factors 14*

No additional explanation required.

*Factor 15: External Review Rights (former UM 8B: Notice of External Review Rights)*

The organization provides written notification to members of the availability of independent, external review of final internal UM determinations.

*Factor 16*

No additional explanation required.

**Exceptions**

Factor 2 is NA if all purchasers of the organization’s services carve out or exclude pharmaceutical management.

Factor 6 is NA if the organization does not process claims.

**Examples**

*Factors 1–15: Easily accessed sources of information*

- Subscriber handbook.
- Practitioner and provider directory.
- Benefits summary materials.
- Subscriber ID card.