# Health Plan Accreditation (HPA) 2023 Marked-Up Standards

## Table of Contents

OLT 4: Continuity and Coordination Between Medical Care and Behavioral Healthcare ........................................ 2
  Element A: Data Collection ........................................................................................................................................ 2

OLT 1: Program Structure ........................................................................................................................................... 7
  Element A: Written Program Description .................................................................................................................. 7

OLT 5: Timeliness of UM Decisions .......................................................................................................................... 11
  Element D: UM Timeliness Report ............................................................................................................................ 11

CR 1: Credentialing Policies ....................................................................................................................................... 13
  Element A: Practitioner Credentialing Guidelines .................................................................................................. 13

ME 2: Subscriber Information .................................................................................................................................... 19
  Element A: Subscriber Information ........................................................................................................................ 19
  Element B: Distribution of Subscriber Information ............................................................................................... 23

ME 7: Member Experience.......................................................................................................................................... 30
  Element A: Policies and Procedures for Complaints ............................................................................................ 30
  Element B: Policies and Procedures for Appeals .................................................................................................... 32
QI 4: Continuity and Coordination Between Medical Care and Behavioral Healthcare

The organization collaborates with behavioral healthcare practitioners to monitor and improve coordination between medical care and behavioral healthcare.

**Intent**

The organization collaborates with behavioral healthcare practitioners and uses information at its disposal to coordinate medical care and behavioral healthcare.

**Element A: Data Collection**

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

1. Exchange of information.
2. Appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in primary care.
3. Appropriate use of psychotropic medications.
4. Management of treatment access and follow-up for members with coexisting medical and behavioral disorders.
5. Primary or secondary preventive behavioral healthcare program implementation.
6. Special needs of members with severe and persistent serious mental illness or serious emotional disturbance.

**Summary of Changes**

**Policy Change**

- Replaced “severe and persistent mental illness” with “serious mental illness” and added “serious emotional disturbance” to the factor 6 stem and explanation.
- Removed the factor 6 exception for organizations that do not have adult membership.

**Scoring**

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**Data source**

Reports, Materials

**Scope of review**

**Product lines**

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

**Documentation**

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

For Renewal Surveys: NCQA reviews the organization’s evidence of collaboration (e.g., joint meeting minutes, communications) on data collection and most recent and previous year's annual data collection reports.
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 factor 1.

Explanation

The organization demonstrates collaboration between its behavioral healthcare delivery system and medical care delivery system.

Collaboration with a managed behavioral healthcare organization (MBHO) for this element is not considered delegation.

**Factor 1: Exchange of information**

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

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

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

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

The organization collects data on:

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

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

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

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

The organization collects data on issues around management of multiple conditions where there are both medical and behavioral health conditions and management across the continuum of care is an issue.

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

**Factor 5: Prevention programs for behavioral healthcare**

The organization collects data on issues that could be preventable if appropriate primary or secondary programs were developed and implemented. The organization identifies the programs that the collaboration deems most appropriate, but is not required to implement the program to meet the element.
Factor 6: Severe and persistent Serious mental illness or serious emotional disturbance

The organization collects data on specific issues around the continuity and coordination of services for members with severe and persistent serious mental illness (SPMI) or serious emotional disturbance (SED).

Exceptions

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

Factor 6 is NA if the organization’s membership does not include adult members.

Related information

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

Note: The use of HEDIS measure results alone may not meet the intent of the element, because the results may not evaluate continuity and coordination of care between practitioners or across settings. However, measure results may be used to identify a continuity and coordination of care area or measure, that goes beyond HEDIS results.

Examples

Factor 1: Exchange of information

- Surveys of behavioral healthcare practitioners and other practitioners regarding information exchanged.
- Evaluation of solicited or unsolicited practitioner reports on communication between behavioral healthcare practitioners and medical practitioners, including protection of privacy.

Factor 2: Diagnosis, treatment and referral

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

Factor 3: Psychotropic medication use

- Analysis of pharmaceutical utilization data for appropriateness of a psychopharmacological medication.
- Evaluation of psychotropic medication utilization data on issues related to multiple-prescribing practitioners.
- Results of the HEDIS measure Antidepressant Medication Management (AMM).
- Results of the HEDIS measure Follow-Up Care for Children Prescribed ADHD Medication (ADD).
- Results of the organization’s documented process for approving use of psychopharmacological medications in specific situations.
- Results of technology assessment to evaluate emerging psychopharmacological medications.
Factor 4: Managing coexisting conditions

- Data on the frequency of behavioral healthcare consultations for medical or surgical inpatients with secondary or tertiary mental health or substance abuse diagnoses.
- Data on the frequency of treatment and follow-up visits following mental health or substance abuse diagnoses.
- Pharmaceutical data on medication interactions to assess coordination of coexisting medical and behavioral problems.
- Results of the HEDIS measure Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC).
- Results of the HEDIS measure Diabetes Monitoring for People With Cardiovascular Diseases and Schizophrenia (SMD).
- Results of the HEDIS measure Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD).

Factor 5: Primary preventive programs

- Data on the need for a prevention of substance abuse program.
- Data on the need for a parenting skills training program.
- Data on the need for a bereavement counseling program.
- Data on the need for a nutritional and body image program for adolescents.
- Data on the need for a stress management program for adults.

Factor 5: Secondary preventive programs

- Data on the need for developmental screening of children in primary care settings.
- Data on the need for ADHD screening of children in primary care settings.
- Data on the need for screening for eating disorders in adolescents in primary care settings.
- Data on the need for behavioral health consultations for members hospitalized for targeted medical or surgical conditions that are known to be associated with behavioral complications or comorbidities.
- Data on the need for postpartum depression screening.

Factor 6: Severe and persistent mental illness

- Results of the HEDIS measure Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD).
- Results of HEDIS measure Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD).
- Results of HEDIS measure Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC).
- Data on frequency of assessment of substance use disorders.
UM 1: Program Structure

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

**Intent**

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

**Element A: Written Program Description**

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.

**Summary of Changes**

**Policy Change**

- Revised the scoring requirements for the Met and Partially Met scoring options.

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**Data source**

Documented process, Reports

**Scope of review**

**Product lines**

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

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

**Documentation**

*For Interim Surveys: NCQA reviews the organization’s 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 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:

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

Decisions about the following do not require medical necessity review:

- Services in the member’s benefits plan that are limited by number, duration or frequency.
- Extension of treatments beyond the specific limitations and restrictions imposed by the member’s benefits plan.
- Care or services whose coverage does not depend on any circumstances.
- Requests for personal care services, such as cooking, grooming, transportation, cleaning and assistance with other activities of daily living (ADL).
• “Experimental” or “investigational” requests that are always excluded and 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.

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: Policies for Appeals and UM 9: Appropriate Handling of Appeals.

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

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.

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, with the exception of UM 5, Element E, which applies to both approvals and denials. 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.
Organization employees and their dependents: The organization may exclude employees and their dependents from the denial and appeal file universe.

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 how the organization addresses sites of behavioral healthcare services (e.g., psychology groups) and the 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 involved 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 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).

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.

**Exceptions**

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

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

**Related information**

*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 covers up to 20 visits but allows 21 visits), the granting of an exception does not set precedent such that a subsequent denial of the same service or a request for an extension or exception is 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.
UM 5: Timeliness of UM Decisions

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

**Intent**

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

**Element D: UM Timeliness Report**

The organization monitors and submits a report for timeliness of:

1. Notification of nonbehavioral UM decisions.
2. Notification of behavioral UM decisions.
3. Notification of pharmacy UM decisions.

**Scoring**

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**Data source**

Reports

**Scope of review**

Product lines

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

**Documentation**

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

**Look-back period**

For First Surveys: 6 months.
For Renewal Surveys: 12 months.

**Explanation**

This element applies to all UM denial determinations resulting from medical necessity review (as defined in UM 1, Element A).

**Factors 1–3**

The organization monitors the timeliness of notification for all requests and, using at least six months of data, calculates the percentage of decisions that adhere to time frames specified in Elements A–C. The six months of data can extend beyond the look-back period, however the report must be completed within the look-back period. At a minimum, the timeliness report calculates rates of adherence to time frames for each category of request (urgent concurrent, urgent preservice, nonurgent preservice, post-service) for each factor. The organization generates reports to reflect differences if its processes or staff vary by product/product line.

**Excluded from the timeliness report**

For all product lines, the organization excludes decisions and notifications for nonemergency transportation approvals.

Timeliness of notifications sent for approvals is not required to be included in factors 1–3.
Exceptions

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

Factor 3 is NA if all purchasers of the organization’s services carve out or exclude pharmaceutical management.

Examples

Timeliness reports

Factor 1: Timeliness of notification of nonbehavioral UM decisions—commercial product line

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¹Numerator: The number of requests meeting the notification time frame.
²Denominator: The total number of all requests.
CR 1: Credentialing Policies

The organization has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members.

Intent

The organization has a rigorous process to select and evaluate practitioners.

Element A: Practitioner Credentialing Guidelines

The organization specifies:

1. The types of practitioners it credentials and recredits.
2. The verification sources it uses.
3. The criteria for credentialing and recredentialing.
4. The process for making credentialing and recredentialing decisions.
5. The process for managing credentialing files that meet the organization’s established criteria.
6. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner.
7. The process for notifying practitioners if information obtained during the organization’s credentialing process varies substantially from the information they provided to the organization.
8. The process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the credentialing committee’s decision.
9. The medical director or other designated physician’s direct responsibility and participation in the credentialing program.
10. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law.
11. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, board certification and specialty.

Summary of Changes

Policy Change

- Revised the scoring requirement for the Met and Partially Met scoring options.

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Data source  
Documented process
Scope of review

Product lines

For Interim Surveys and First Surveys, this element applies to all product lines.
For Renewal Surveys, this element applies to the Medicaid product line only.

Documentation

NCQA reviews the organization’s policies and procedures in effect 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.

Practitioners within the scope of credentialing

Practitioners are within the scope of credentialing if all criteria listed below are met:

- Practitioners are licensed, certified or registered by the state to practice independently (without direction or supervision).
- Practitioners have an independent relationship with the organization.
  - An independent relationship exists when the organization directs its members to see a specific practitioner or group of practitioners, including all practitioners whom member can select as primary care practitioners.
- Practitioners provide care to members under the organization’s medical benefits.

The listed criteria apply to practitioners in the following settings:

- Individual or group practices.
- Facilities.
- Rental networks:
  - That are part of the organization’s primary network and the organization has members who reside in the rental network area.
  - Specifically for out-of-area care and members may see only those practitioners or are given an incentive to see rental network practitioners.
- Telemedicine.

Factor 1: Types of practitioners

Credentialing policies and procedures include the following types of practitioners.

- Medical practitioners:
  - Medical doctors.
  - Oral surgeons.
  - Chiropractors.
  - Osteopaths.
  - Podiatrists.
  - Nurse practitioners.
  - Other medical practitioners who may be within the scope of credentialing.
  - NCQA does not include these practitioners in the credentialing file review.
• **Behavioral healthcare practitioners:**
  – Psychiatrists and other physicians.
  – Addiction medicine specialists.
  – Doctoral or master’s-level psychologists.
  – Master’s-level clinical social workers.
  – Master’s-level clinical nurse specialists or psychiatric nurse practitioners.
  – Other behavioral healthcare specialists who may be within the scope of credentialing.

**Factor 2: Verification sources**

Credentialing policies and procedures describe the sources the organization uses to verify credentialing information. The organization uses any of the following sources to verify credentials:

- The primary source (or its website).
- A contracted agent of the primary source (or its website).
  – The organization obtains documentation indicating a contractual relationship between the primary source and the agent that entitles the agent to verify credentials on behalf of the primary source.
- An NCQA-accepted source listed for the credential (or its website).

**Factors 3, 4: Decision-making criteria and process**

The organization:

- Credentials practitioners before they provide care to members.
- Has a process for making credentialing decisions, and defines the criteria it requires to reach a credentialing decision.
  – Criteria are designed to assess a practitioner’s ability to deliver care.
- Determines which practitioners may participate in its network.

**Factor 5: Managing files that meet the criteria**

Credentialing policies and procedures describe the process used to determine and approve files that meet criteria (i.e., clean files). The organization may present all practitioner files to the Credentialing Committee or may designate approval authority of clean files to the medical director or to an equally qualified practitioner.

**Factor 6: Nondiscriminatory credentialing and recredentialing**

Credentialing policies and procedures:

- State that the organization does not base credentialing decisions on an applicant’s race, ethnic/national identity, gender, age, sexual orientation or patient type (e.g., Medicaid) in which the practitioner specializes.
- Specify the process for preventing discriminatory practices.
  – Preventing involves taking proactive steps to protect against discrimination occurring in the credentialing and recredentialing processes.
- Specify how the organization monitors the credentialing and recredentialing processes for discriminatory practices, at least annually.
  – Monitoring involves tracking and identifying discrimination in credentialing and recredentialing processes.
**Factor 7: Discrepancies in credentialing information**

Credentialing policies and procedures describe the organization’s process for notifying practitioners when credentialing information obtained from other sources varies substantially from that provided by the practitioner.

**Factor 8: Notification of decisions**

Credentialing policies and procedures specify that the organization’s time frame for notifying applicants of initial credentialing decisions and recredentialing denials does not exceed 60 calendar days from the Credentialing Committee’s decision. The organization is not required to notify practitioners regarding recredentialing approvals.

**Factor 9: Participation of a medical director or designated physician**

Credentialing policies and procedures describe the medical director or other designated physician’s overall responsibility and participation in the credentialing process.

**Factor 10: Ensuring confidentiality**

Credentialing policies and procedures describe the organization’s process for ensuring confidentiality of the information collected during the credentialing process and the procedures it uses to keep this information confidential.

**Factor 11: Practitioner directories and member materials**

Credentialing policies and procedures describe the organization’s process for ensuring that information provided in member materials and practitioner directories is consistent with the information obtained during the credentialing process.

**Exception**

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

**Related information**

*Appropriate documentation.* Credentialing policies and procedures define the organization’s process for documenting information and activities in credentialing files. The organization documents verification in the credentialing files using any of the following methods or a combination:

- Credentialing documents signed (or initialed) and dated by the verifier.
- A checklist that includes for each verification:
  - The source used.
  - The date of verification.
  - The signature or initials of the person who verified the information.
    - Typed initials are only acceptable if there is a unique electronic signature or identifier on the checklist.
  - The report date, if applicable.
- A checklist with a single signature and a date for all verifications that has a statement confirming the signatory verified all of the credentials on that date and that includes for each verification:
  - The source used.
  - The report date, if applicable.
Verification from a report. NCQA uses the date generated by the source when the information is retrieved. If the source report does not generate a date, NCQA uses the date noted in the credentialing file by the organization staff who verified the credentials. Staff who verified the credentials must sign or initial the verification.

Automated credentialing system. The organization may use an electronic signature or unique electronic identifier of staff to document verification if it can demonstrate that the electronic signature or unique identifier can only be entered by the signatory. The organization provides its security and login policies and procedures to confirm the unique identifier and the signature can only be entered by the signatory. The system must identify the individual verifying the information, the date of verification, the source and the report date, if applicable.

- Faxed, digital, electronic, scanned or photocopied signatures are acceptable. Signature stamps are not acceptable.
- If the checklist does not include checklist requirements listed above, appropriate credentialing information must be included.

Use of web crawlers. The organization may use web crawlers to verify credentialing information from approved sources. A “web crawler” is software that retrieves information directly from a website; in this case, the state licensing or certification agency (i.e., the primary source). The organization provides documentation that the web crawler collects information only from approved sources, and documents that staff reviewed the credentialing information.

Provisional credentialing. If the organization decides to provisionally credential practitioners, it:

- Has a process for one-time provisional credentialing of practitioners applying to its network for the first time.
- Verifies the following within the required time limits:
  - A current, valid license to practice (CR 3: Credentialing Verification, Element A, factor 1).
  - The past five years of malpractice claims or settlements from the malpractice carrier, or the results of the National Practitioner Data Bank (NPDB) query (CR 3, Element A, factor 6).
  - A current and signed application with attestation (CR 3, Element C, factors 1–6).
- Follows the same process for presenting provisional credentialing files to the Credentialing Committee or medical director as it does for its regular credentialing process.
- Does not perform provisional credentialing for practitioners who were credentialed by a delegate on behalf of the organization.
- Does not hold practitioners in provisional status for longer than 60 calendar days.
- Does not list provisionally credentialed practitioners in the directory.
- Does not allow practitioners to deliver care prior to completion of provisional credentialing.

Practitioners who do not need to be credentialed.

- Practitioners who practice exclusively in an inpatient setting and provide care for organization members only because members are directed to the hospital or another inpatient setting.
• Practitioners who practice exclusively in free-standing facilities and provide care for organization members only because members are directed to the facility.

• Pharmacists who work for a pharmacy benefits management (PBM) organization to which the organization delegates utilization management (UM) functions.

• Covering practitioners (e.g., locum tenens).
  – Locum tenens who do not have an independent relationship with the organization are outside NCQA’s scope of credentialing.

• Practitioners who do not provide care for members (e.g., board-certified consultants who may provide a professional opinion to the treating practitioner).

• Rental network practitioners who provide out-of-area care only, and members are not required or given an incentive to seek care from them.

Practitioner termination and reinstatement. The organization:

• Initially credentials a practitioner again if the break in network participation is more than 30 calendar days.

• Re-verifies credentials that are no longer within verification time limits.

• Re-verifies credentials that will not be in effect when the Credentialing Committee or medical director makes the credentialing decision.

Examples

Factor 6: Nondiscriminatory credentialing and recredentialing

The organization monitors credentialing decisions to prevent discrimination. Monitoring includes, but is not limited to:

• Maintaining a heterogeneous credentialing committee membership and the requirement for those responsible for credentialing decisions to sign a statement affirming that they do not discriminate.

• Periodic audits of credentialing files (in-process, denied and approved files) that suggest potential discriminatory practice in selecting practitioners.

• Annual audits of practitioner complaints for evidence of alleged discrimination.

Automated credentialing systems

• Adobe Sign.

• DocuSign.
ME 2: Subscriber Information

The organization provides each subscriber with the information necessary to understand benefit coverage and obtain care.

Intent

The organization informs subscribers about benefits and access to medical services.

Element A: Subscriber Information

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

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 internal UM final determinations.
16. How the organization evaluates new technology for inclusion as a covered benefit.

Summary of Changes

Clarification

• Divided Element A into two elements.

Scoring

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Data source

Reports, Materials
Scope of review

Product lines

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

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

Documentation

NCQA reviews the organization’s subscriber information that is in place throughout the look-back period.

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

For First Surveys: NCQA reviews the following:

• The most recent distribution of information to subscribers for all factors, and
• Evidence that the organization distributed the information to subscribers.

For Renewal Surveys: NCQA reviews the following:

• The most recent and the previous year’s distribution of information to subscribers for all factors, and
• The previous year’s distribution of information to subscribers for factors 1-14 and 16.
• Evidence that the organization distributed the information to subscribers.

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, with the exception of factor 5, which may be delegated to an organization with NCQA MHC Distinction.

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 subscribers by mail, fax or email.

The organization may include the information on its website if it informs subscribers 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 also informs subscribers that the statement is available through alternative media on request.

Factor 1: Benefits and services

The written subscriber information distributed to subscribers explains the scope and limitations of benefits and services. The materials may include broad statements about exclusions (e.g., experimental or investigation services) without specifying the service or procedure provided 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.
Factor 2: Pharmaceutical management

The written subscriber information 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: After-hours and emergent care
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.

Factor 14: Appealing a decision
The organization provides details about its appeal process, for coverage and noncoverage appeals, which may include:
- Time frames for members to file an appeal.
- Time frames for deciding the appeal.
- The procedures for filing an appeal, including where to direct the appeal and information to include in the appeal.

Factor 15: External review rights
The organization provides written notification to subscribers of the availability of independent, external review of internal UM final determinations.

Factor 16: Evaluating new technology for inclusion as a covered benefit
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.
Factor 15 is NA for appeals:
- By members covered by Medicare, Medicaid or the Federal Employees Health Benefits (FEHB) Program.
- By members in self-funded accounts.
- By members whose employer has arranged for employees to have access to employer-mandated independent review.

Related information
Use of vendors/mail service organizations for distribution of subscriber information.
If the organization contracts with a mail service organization to provide distribution services, it provides access to the mail service organization’s documentation for evaluation. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under ME 8. Refer to Vendors in Appendix 2.

Examples
Factors 1–16: Sources of information for subscribers
- Subscriber handbook.
- Practitioner and provider directory.
- Benefits summary materials.
- Subscriber ID card.
Element B: Distribution of Subscriber Information

The organization distributes its subscriber information to the following groups:

1. New members, upon enrollment.
2. Existing members, annually.

Summary of Changes

Clarification
- Divided Element A into two elements.

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Data source
- Reports

Scope of review
- Product line
  - *This element applies to First Surveys and Renewal Surveys for all product lines.*

Documentation

*For First Surveys and Renewal Surveys:* NCQA reviews evidence of the organization’s distribution of materials containing the subscriber information to members at enrollment during the look-back period.

NCQA also reviews evidence of the organization’s distribution of materials containing the subscriber information to existing members during the look-back period, annually.

Look-back period
- *For First Surveys:* 6 months.
- *For Renewal Surveys:* 24 months.

Explanation

Distribution of subscriber information

The organization distributes information to subscribers by mail, fax or email.

The organization may include the information on its website if it informs subscribers 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 also informs subscribers that the statement is available through alternative media on request.

Factor 1

No additional explanation required.

Factor 2

The organization provides documentation of distribution of subscriber information to members annually.
Exception
None.

Related information
Use of vendors/mail service organizations for distribution of subscriber information. If the organization contracts with a mail service organization to provide distribution services, it provides access to the mail service organization’s documentation for evaluation. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under ME 8. Refer to Vendors in Appendix 2.

Examples
None.
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 A: Policies and Procedures for Complaints**

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

1. Documentation of the substance of complaints and actions taken.
2. Investigation of the substance of complaints.
3. Notification to members of the resolution of the complaint and, if there is an adverse decision, the right to appeal.
4. Standards for timeliness, including standards for urgent situations.
5. Provision of language services for the complaint process.

**Summary of Changes**

**Policy Change**

- Revised the scoring requirement for the Met, Partially Met and Not Met scoring options.

**Scoring**

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Documented process

**Scope of review**

**Product lines**

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

**Documentation**

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.

This element applies to all complaints that do not become requests for coverage or requests to overturn a decision.

Complaints resolved during the first contact must be categorized as complaints and included in the analysis in ME 7, Elements C and E.
**Factor 1: Documentation**

The organization’s documentation of the complaint includes:

- The member’s reason for making the complaint.
- Actions taken, including, but not limited to:
  - The member’s previous complaint history.
  - Follow-up activities associated with the complaint.

**Factor 2: Investigation**

The organization investigates the content of the complaint, including all issues relevant to the complaint, and documents its findings.

The organization’s policies and procedures for resolving quality-of-care complaints specify when practitioner review is required.

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

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

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

For the Medicare product line, the organization is not required to notify members of the right to appeal a grievance decision.

**Factor 4: Timeliness**

The organization sets timeliness standards for registering and responding to complaints. The organization’s timeliness and notification standards consider urgency, as defined by the organization.

**Factor 5: Language services**

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

Use of contracted translation services is not considered delegation.

**Exceptions**

None.

**Examples**

**Factor 5: Language services**

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

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

1. Documentation of the substance of appeals and actions taken.
2. Investigation of the substance of appeals.
3. Notification to members of the disposition of appeals and the right to further appeal, as appropriate.
4. Standards for timeliness, including standards for urgent situations.
5. Provision of language services for the appeal process.

Summary of Changes

Policy Change

- Revised the scoring requirement for the Met, Partially Met and Not Met scoring options.

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Documented process

Scope of review

Product lines

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

Documentation

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

The organization’s documentation of the appeal includes:

- The member’s reason for appealing the previous decision.
- Actions taken, including, but not limited to:
  - The member’s previous appeal history.
  - Follow-up activities associated with the appeal.
Factor 2: Investigation
The organization investigates the content of the appeal, including all issues relevant to the appeal, and documents its findings.

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

Factor 4: Timeliness
The organization sets timeliness standards for registering and responding to appeals. The organization’s timeliness and notification standards consider urgency, as defined by the organization.

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

Exception
This element is NA for the Medicare product line.

Examples
Appeals of decisions that are not about coverage
- The organization denied a member’s sixth request in 12 months to change primary care practitioners.
- A member’s coverage was terminated for non-payment of premium, but the member had cancelled checks as proof of payment.
- Member appeals being placed in a restricted pharmacy program (the member must get all based on prescription history).
- A member appealed the organization’s payment to a practitioner because of a significant concern with the quality of care.
- A member whose primary language was not English requested language assistance. The organization denied the request, stating that the population of members who spoke the language was too small to support language assistance. The member appealed the decision.

Factor 5: Language services
- Oral interpretation of documents 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.