Health Plan Accreditation 2024

Standards for Population Health Management

Standards for Member Experience

PHM 2: Population Identification

The organization systematically collects, integrates and assesses member data to inform its population health management programs.

Intent

The organization assesses the needs of its population and determines actionable categories for appropriate intervention.

Element A: Data Integration

The organization integrates the following data to use for population health management functions:

1. **Medical and behavioral claims or encounters.**
2. **Pharmacy claims.**
3. **Laboratory results.**
4. **Health appraisal results.**
5. **Electronic health records.**
6. **Health services programs within the organization.**
7. **Advanced data sources.**

Summary of Changes

- No changes to this element.

Scoring

Met	Partially Met	Not Met
The organization meets ~~3~~5-7 factors	The organization meets 2-4 factors	The organization meets 0-1 factors

Data source Documented process, Reports, Materials

Scope of review

Product lines

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

Documentation

For Interim Surveys: NCQA reviews the organization's documented process for the types and sources of integrated data.

For First and Renewal Surveys: NCQA reviews reports or materials (e.g., screenshots) for evidence that the organization integrated data types and data from sources listed in the factors. The organization may submit multiple examples that collectively demonstrate integration from all data types and sources, or may submit one example that demonstrates integration of all data types and sources.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

Data integration is combining data from multiple sources or databases. Data may be combined from multiple systems and sources (e.g., claims, pharmacy), across care sites (e.g., inpatient, ambulatory, home) and across domains (e.g., clinical, business, operational). The organization may limit data integration to the minimum necessary to identify eligible members and determine and support their care needs.

***Factor 1:* Claims or encounter data**

Requires both medical and behavioral health claims or encounters. Behavioral health claims data are not required if all purchasers of the organization's services carve out behavioral healthcare services.

Factors 2, 3

No additional explanation required.

***Factor 4:* Health appraisals**

The organization demonstrates the capability to integrate data from health appraisals and health appraisals should be integrated if elected by plan sponsor.

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

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

***Factor 6:* Health service programs within the organization.**

Relevant organization programs may include utilization management, care management or wellness coaching programs. The organization has a process for integrating relevant or necessary data from other programs to support identification of eligible members and determining care needs. Health appraisal results do not meet this factor.

***Factor 7:* Advanced data sources**

Advanced data sources aggregate data from multiple entities such as all-payer claims systems, regional health information exchanges and other community collaboratives. The organization must have access to the data to meet the intent of this factor.

Exceptions

None.

Related information

The data sources that meet factors 1–6 may not be used to meet factor 7.

A vendor relationship exists if the organization contracts with a NCQA-Prevalidated Health IT Solution to perform these functions.

Use of vendors for usability testing services. If the organization contracts with a vendor to provide usability testing services, it provides access to the vendor's documentation. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under *PHM 7: Delegation of PHM*. NCQA evaluates the vendor's documentation against the requirements. Refer to *Vendors in Appendix 2: Delegation and Automatic Credit Guidelines.*

Examples

***Factor 5:* EHR integration**

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

***Factor 6:* Health services programs within the organization**

- Case management.
- UM programs.
  - Daily hospital census data captured through UM.
  - Diagnosis and treatment options based on prior authorization data.
- Disease management.
- Wellness coaching.
- Health information line.

***Factor 7:* Advanced data sources**

Advanced data sources may require two-way data transfer: The organization and other entities can submit data to the source and can use data from the same source. These include, but are not limited to**:**

- Regional, community or health system health information exchanges (HIE).
- All-payer databases.
- Integrated data warehouses between providers, practitioners, and the organization with all parties contributing to and using data from the warehouse.
- State or regionwide immunization registries.

PHM 5: Complex Case Management

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

Intent

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

Element C: Case Management Process

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

1. **Initial assessment of member health status, including condition-specific issues.**
2. **Documentation of clinical history, including medications.**
3. **Initial assessment of the activities of daily living.**
4. **Initial assessment of behavioral health status, including cognitive functions.**
5. **Initial assessment of social determinants of health.**
6. **Initial assessment of life-planning activities.**
7. **Evaluation of cultural and linguistic needs, preferences or limitations.**
8. **Evaluation of visual and hearing needs, preferences or limitations.**
9. **Evaluation of caregiver resources and involvement.**
10. **Evaluation of available benefits.**
11. **Evaluation of community resources.**
12. **Development of an individualized case management plan, including prioritized goals and considers member and caregiver goals, preferences and desired level of involvement in the case management plan.**
13. **Identification of barriers to the member meeting goals or complying with the case management plan.**
14. **Facilitation of member referrals to resources and a follow-up process to determine whether members act on referrals.**
15. **Development of a schedule for follow-up and communication with members.**
16. **Development and communication of a member self-management plan.**
17. **A process to assess member progress against the case management plan.**

Scoring

Met	Partially Met	Not Met
The organization meets ~~12~~14-17 factors	The organization meets 8-~~11~~13 factors	The organization meets 0-7 factors

Data source Documented process

Scope of review

Product lines

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

Documentation

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

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

Explanation

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

Assessment and evaluation

Assessment and evaluation each require the case manager or other qualified individual to draw and document a conclusion about data or information collected. If the organization's CM system automatically generates suggestions, the case manager or other individual must still document their own conclusions. It is not sufficient to just have raw data or answers to questions. Policies describe the process to both collect information and document a summary of the meaning or implications of that data or information to the member's situation, so that it can be used in the case management plan.

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

Complex case management policies and procedures state why an assessment might not be appropriate for a factor (e.g., life-planning activities, in pediatric cases). The organization records the specific factor and the reason in the case management system and file.

***Factor 1:* Initial assessment of member's health status**

Complex case management policies and procedures specify the process for initial assessment of health status, specific to an identified condition and likely comorbidities (e.g., high-risk pregnancy and heart disease, for members with diabetes). The assessment includes:

- Screening for presence or absence of comorbidities and their current status.
- Member's self-reported health status.
- Information on the event or diagnosis that led to the member's identification for complex case management.
- Current medications, including schedules and dosages.

***Factor 2:* Documentation of clinical history**

Complex case management policies and procedures specify the process for documenting clinical history, including:

- Past hospitalization and major procedures, including surgery.
- Significant past illnesses and treatment history.
- Relevant past medications related to the member's condition.

Dates are a necessary component of accurate documentation of the member's clinical history. To the extent possible, the organization collects dates as part of documenting clinical history; however, NCQA does not penalize an organization if a member or other individual providing the information cannot provide dates. If dates are not present in the file, NCQA reviews the organization's complex case management policies and procedures. If the organization has a process for

collecting dates as part of the clinical history, NCQA assumes the file does not include dates because the member or other individual giving information did not provide dates. The requirement is not met if the organization does not have a process for collecting dates as part of the clinical history.

Factor 2 does not require assessment or evaluation.

Factor 3: **Initial assessment of activities of daily living**

Complex case management policies and procedures specify the process for assessing functional status related to at least the six basic ADLs: bathing, dressing, going to the toilet, transferring, feeding and continence.

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

Complex case management policies and procedures specify the process for assessing behavioral health status, including:

- Cognitive functions:
  - The member's ability to communicate and understand instructions.
  - The member's ability to process information about an illness.
- Mental health conditions.
- Substance use disorders.

Factor 5: **Initial assessment of social determinants of health**

Complex case management policies and procedures specify the process for assessing social determinants of health,[1] which are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks that may affect a member's ability to meet case management goals.

Because social determinants of health are a combination of influences, the organization considers more than one social determinant of health, for a comprehensive overview of the member's health.

Factor 6: **Initial assessment of life-planning activities**

Complex case management policies and procedures specify the process for assessing whether members have completed life-planning activities such as wills, living wills or advance directives, health care powers of attorney and Medical or Physician Orders of Life-Sustaining Treatment (MOLST or POLST) forms.

If life planning activities are determined to be appropriate, the case manager documents what activities the member has taken and what documents are in place. If determined not to be appropriate, the case manager documents the reason in the case management record or file.

Providing life-planning information (e.g., brochure, pamphlet) to all members in case management meets the intent of this factor.

Factor 7: **Evaluation of cultural and linguistic needs**

Complex case management policies and procedures specify a process for assessing culture and language to identify potential barriers to effective communication or care and acceptability of specific treatments. Policies and procedures also include consideration of cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

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

Factor 8: **Evaluation of visual and hearing needs**

Complex case management policies and procedures specify a process for assessing vision and hearing to identify potential barriers to effective communication or care.

Factor 9: **Evaluation of caregiver resources**

Complex case management policies and procedures specify a process for assessing the adequacy of caregiver resources (e.g., family involvement in and decision making about the care plan) during member evaluation.

Factor 10: **Evaluation of available benefits**

Complex case management policies and procedures specify a process for assessing the adequacy of health benefits regarding the ability to fulfill a treatment plan. Assessment includes a determination of whether the resources available to the member are adequate to fulfill the treatment plan.

Factor 11: **Evaluation of community resources**

Complex case management policies and procedures specify a process for assessing eligibility for community resources that supplement those for which the organization has been contracted to provide. At a minimum, these include:

- Community mental health.
- Transportation.
- Wellness organizations.
- Palliative care programs.
- Nutritional support.

Factor 12: **Individual case management plan and goals**

Complex case management policies and procedures specify a process for creating a personalized case management plan that meets member needs and includes:

- Prioritized goals.
  - Prioritized goals consider member and caregiver needs and preferences; they may be documented in any order, as long as the level of priority is clear.
- Time frames for reevaluation of goals.
  - Time frames are specified in the complex case management plan.
- Resources to be utilized, including appropriate level of care.
- Planning for continuity of care, including transition of care and transfers between settings.
- Collaborative approaches to be used, including level of family participation.

Factor 13: **Identification of barriers**

Complex case management policies and procedures address barriers to a member receiving or participating in a case management plan. A barrier analysis can assess:

- Language or literacy level.
- Access to reliable transportation.
- Understanding of a condition.
- Motivation.

- Financial or insurance issues.
- Cultural or spiritual beliefs.
- Visual or hearing impairment.
- Psychological impairment.

The organization documents that it assessed barriers, even if none were identified.

Factor 14: **Referrals to available resources**

Complex case management policies and procedures specify a process for facilitating referral to other health organizations, when appropriate.

Factor 15: **Follow-up schedule**

Complex case management policies and procedures specify a process for determining if follow-up is appropriate or necessary (for example, after a member is referred to a disease management program or health resource). The complex case management plan contains a schedule for follow-up that includes, but is not limited to:

- Counseling.
- Follow-up after referral to a DM program.
- Follow-up after referral to a health resource.
- Member education.
- Self-management support.
- Determining when follow-up is not appropriate.

Factor 16: **Development and communication of self-management plans**

Complex case management policies and procedures specify a process for communicating the self-management plan to the member or caregiver (i.e., verbally, in writing). **Self-management plans** are activities that help members manage a condition and are based on instructions or materials provided to them or to their caregivers.

Factor 17: **Assessing progress**

Complex case management policies and procedures specify a process for assessing progress toward overcoming barriers to care and to meeting treatment goals, and for assessing and adjusting the care plan and its goals, as needed.

Exceptions

None.

Examples

Factor 3: **Activities of daily living**

- Dressing.
- Bathing.
- Toileting.
- Eating.
- Transferring (e.g., getting in and out of chairs).

Factor 4: **Cognitive functioning assessment**

- Alert/oriented, able to focus and shift attention, comprehends and recalls direction independently.

- Requires prompting (cuing, repetition, reminders) only under stressful situations or unfamiliar conditions.
- Requires assistance and some direction in specific situations (e.g. on all tasks involving shifting attention) or consistently requires low stimulus environment due to distractibility.
- Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state or delirium.

Factor 5: **Social determinants of health**

- Current housing and housing security.
- Access to local food markets.
- Exposure to crime, violence and social disorder.
- Residential segregation and other forms of discrimination.
- Access to mass media and emerging technologies.
- Social support, norms and attitudes.
- Access, transportation and financial barriers to obtaining treatment.

Factor 7: **Cultural needs, preferences or limitations**

- Health care treatments or procedures that are discouraged or not allowed for religious or spiritual reasons.
- Family traditions related to illness, death and dying.
- Health literacy assessment.
- Dietary restrictions.

Factor 9: **Caregiver assessment**

- Member is independent and does not need caregiver assistance.
- Caregiver currently provides assistance.
- Caregiver needs training, supportive services.
- Caregiver is not likely to provide assistance.
- Unclear if caregiver will provide assistance.
- Assistance needed but no caregiver available.

Factor 10: **Assessment of available benefits**

- Benefits covered by the organization and by providers.
- Services carved out by the purchaser.
- Services that supplement those the organization has been contracted to provide, such as:
  - Community mental health.
  - Medicaid.
  - Medicare.
  - Long-term care and support.
  - Disease management organizations.
  - Palliative care programs.

Factor 13: **Assessment of barriers**

- Does the member understand the condition and treatment?
- Does the member want to participate in the complex case management plan?
- Does the member believe that participation will improve health?
- Are there financial or transportation limitations that may hinder the member from participating in care?
- Does the member have the mental and physical capacity to participate in care?

Source: Lorig, K., Patient Education, A Practical Approach (Thousand Oaks, CA: Sage Publications, 2001) 186–92.

Factor 16: **Self-management**

- Self-management includes ensuring that the member can:
  - Perform activities of daily living (e.g., transfer/ambulation, bathing, dressing, toileting, eating/feeding).
  - Perform instrumental activities of daily living (e.g., meals, housekeeping, laundry, telephone, shopping, finances).
  - Self-administer medication (e.g., oral, inhaled or injectable).
  - Self-administer medical procedures/treatments (e.g., change wound dressing).
  - Manage equipment (e.g., oxygen, IV/infusion equipment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies).
  - Maintain a prescribed diet.
  - Chart daily weight, blood sugar.

ME 5: Pharmacy Benefit Information

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

Intent

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

Element A: Pharmacy Benefit Information—Website

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

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

Summary of Changes

- No changes to this element.

Scoring

Met	Partially Met	Not Met
The organization meets 4<u>5</u>-6 factors	The organization meets 2-~~3~~<u>4</u> factors	The organization meets 0-1 factors

Data source Documented process, Reports, Materials

Scope of review

Product lines

This element applies to First Surveys for all product lines.

Documentation

NCQA reviews the organization's website content and functionality against the requirements of this element. Both must be in place throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen shots of web functionality, supplemented with documents specifying the required features and functions of the site. If screen shots provided include detailed explanations of how the site works, there is no need to provide supplemental documents.

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

Explanation

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

One attempt or contact

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

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

***Factor 1:* Financial responsibility**

The organization's website:

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

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

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

***Factor 2:* Exceptions process**

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

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

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

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

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

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

No additional explanation required.

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

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

Exceptions

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

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

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

Related information

Use of vendors. NCQA considers the use of a PBM or contracting with a similar organization to be delegation, except for factors 3–5.

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

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

Examples

***Factor 1:* Financial responsibility**

The organization's website contains the following statements:

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

Element B: Pharmacy Benefit Information—Telephone

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

1. Determine their financial responsibility for a drug, based on the pharmacy benefit.

2. Initiate the exceptions process.

3. Order a refill for an existing, unexpired, mail-order prescription.

4. Find the location of an in-network pharmacy.

5. Conduct a proximity search based on zip code.

6. Determine the availability of generic substitutes.

Scoring

Met	Partially Met	Not Met
The organization meets 4<u>5</u>-6 factors	The organization meets 2-~~3~~<u>4</u> factors	The organization meets 0-1 factors

Data source Documented process, Reports, Materials

Scope of review

Product lines

This element applies to First Surveys for all product lines.

Documentation

NCQA reviews evidence of how the organization's telephone system meets each factor throughout the look-back period.

For live-person systems: NCQA reviews policies and procedures, scripts and other resources used by Member Services staff.

For automated systems: NCQA reviews evidence of functional capability or scripts, supplemented with documents specifying the required features and stating that the telephone system functions as required.

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

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

One attempt or contact

The organization meets the requirement of "one attempt or contact" if members can complete all the required functions over the telephone without the need to make more than one call. The organization may have an automated system that answers and triages an initial call, but once the member reaches a live person, providing the member with another number to call, transferring the member to voicemail or into a phone queue does not meet the requirement.

The organization may use:

- A live-person or automated telephone system to provide the information, ***or***
- A live-person telephone transfer to another person or organization.

After-hours calls

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

Factor 1: **Financial responsibility**

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

Factor 2: **Exceptions process**

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

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

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

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

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

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

No additional explanation required.

Factor 6: **Availability of generic substitutes**

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

Exceptions

This element is NA if all purchasers of the organizations carve out or exclude the pharmacy benefit.

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

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

Related information

Factor 6: Clinical information. Member Services staff are not expected to answer clinical questions. Members may receive a return call from a pharmacist or clinician within 24 hours, or may be transferred directly to a pharmacist or clinician.

Examples None.

ME 6: Personalized Information on Health Plan Services

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

Intent

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

Element D: Email Response Evaluation

The organization:

1. **Has a process for responding to member email inquiries within one business day of submission.**
2. **Has a process for annually evaluating the quality of email responses.**
3. **Annually collects data on email turnaround time.**
4. **Annually collects data on the quality of email responses.**
5. **Annually analyzes data.**
6. **Annually acts to improve identified deficiencies.**

Scoring

Met	Partially Met	Not Met
The organization meets 4~~5~~-6 factors	The organization meets 2-~~3~~4 factors	The organization meets 0-1 factors

Data source Documented process, Reports

Scope of review

Product lines

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

Documentation

NCQA reviews the organization's policies and procedures in place throughout the look-back period for factors 1 and 2.

For First Surveys: NCQA also reviews the organization's most recent annual evaluation report and actions completed within the look-back period for factors 3–6.

For Renewal Surveys: NCQA also reviews the organization's previous and most recent annual evaluation report and actions completed within the look-back period for factors 3–6.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

This requirement applies to any email address that is communicated to members (e.g., in member materials, website, newsletter) as a method for contacting the organization.

This requirement applies to all member emails, including duplicate inquiries.

Although the intent of the element is to provide an electronic customer service function via email, if the organization does not provide this email function but uses a member portal to communicate with members instead, it may opt to have NCQA

review and score the portal functions. Services provided by the portal must meet all requirements in Element D.

***Factor 1:* Email inquiries**

Responding to member emails verbally does not meet the intent of the requirement.

A system-generated, automatic email acknowledgment of receipt of a question or notification of when a member can expect a researched response does not meet the intent of the requirement.

If responding to member email inquiries requires additional time, it is acceptable to send the member an email that describes the member's specific issue and the investigation that is in process.

***Factors 2–4:* Process to measure quality**

The data collection methodology produces valid and reliable results.

***Factors 3–4:* Data collection**

The organization collects information data on both the turnaround time and the email responses. When the organization measures quality, it measures how useful or understandable the email is.

***Factor 5:* Quantitative and qualitative analysis**

For initial measurement, the organization conducts quantitative and qualitative analysis of data.

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

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

***Factor 6:* Acting to improve**

The organization takes at least one action to improve deficiencies identified from the analyses conducted for factor 5. Interventions relate directly to the cause of the deficiency identified in the qualitative analysis.

Exception

Factor 6 is NA if no deficiencies are identified. NCQA evaluates whether this conclusion is reasonable, given assessment results.

Examples None.

