

Managed Behavioral Health Organization (MBHO) 2023 Marked-Up Standards

Table of Contents

CC 1: Coordination of Behavioral Healthcare.....	2
Element B: Opportunities for Coordination	2
UM 5: Timeliness of UM Decisions.....	4
Element B: UM Timeliness Report.....	4
CR 1: Credentialing Policies.....	6
Element A: Practitioner Credentialing Guidelines.....	6
RR 2: Policies and Procedures for Complaints and Appeals.....	12
Element A: Policies and Procedures for Complaints.....	12
Element B: Policies and Procedures for Appeals	14
RR 3: Subscriber Information	16
Element A: Subscriber Information	16
Element B: Distribution of Subscriber Information.....	19

CC 1: Coordination of Behavioral Healthcare

The organization monitors the continuity and coordination of care that members receive across the behavioral healthcare network and takes action, as necessary, to improve and measure the effectiveness of these actions.

Intent

The organization uses information at its disposal to facilitate and measure the effectiveness of improvement actions related to continuity and coordination of behavioral healthcare across its delivery system.

Element B: Opportunities for Coordination

The organization annually selects at least one opportunity to improve coordination of behavioral healthcare in each of the following categories:

1. Exchange of information across the continuum of behavioral healthcare services.
2. Access and follow-up with appropriate behavioral healthcare practitioners in the network.
3. Appropriate use of psychotropic medications.
4. Special needs of members with ~~severe and persistent mental illness (SPMI)~~ 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 4 stem and explanation.

Scoring	100%	80%	50%	20%	0%
	The organization meets 3-4 factors	No scoring option	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source	Reports
Scope of review	<p><i>For Initial Surveys:</i> NCQA reviews the organization’s most recent report on opportunities for improvement.</p> <p><i>For Renewal Surveys:</i> NCQA reviews the organization’s most recent and previous year’s reports on opportunities for improvement.</p>
Look-back period	<p><i>For Initial Surveys:</i> At least once during the prior year.</p> <p><i>For Renewal Surveys:</i> 24 months.</p>
Explanation	<p>THIS IS A CORE ELEMENT. The organization must meet this requirement even if it does not have any clients or serve as a delegate.</p> <p>Selecting opportunities for improvement</p> <p>The organization uses quantitative and qualitative analyses to prioritize and select opportunities for improvement from the information collected and analyzed in Element A.</p>

The organization identifies multiple areas, or measures, for improvement, based on its analysis, and selects four opportunities for improvement.

NCQA considers each area, or measure, identified for improvement as one opportunity, and counts only one opportunity per measure for factors 1–4. Opportunities may address areas, or measures, related to transitions or settings and are not required to address both.

Because opportunities for improvement can change with each analysis, the organization may present different opportunities for each annual analysis.

Factor 1: Exchange of information across the continuum

The organization identifies an opportunity to improve exchange of information across the continuum of behavioral healthcare that focuses on any or all of the following:

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

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

Factor 2: Access and follow-up with appropriate practitioners

No explanation required.

Factor 3: Appropriate use of psychotropic medications

The organization identifies an opportunity to improve behavioral health practitioner adherence to prescribing guidelines. Efforts to improve the HEDIS measures Antidepressant Medication Management or Follow-Up Care for Children Prescribed ADHD Medication meet the requirements of this factor.

Factor 4: Members with ~~SPMI~~ serious mental illness or serious emotional disturbance

The organization identifies an opportunity to improve issues of continuity and coordination of services for members with ~~SPMI~~ serious mental illness (SMI) or serious emotional disturbance (SED).

Exceptions

None.

Examples

None.

UM 5: Timeliness of UM Decisions

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

Intent

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

Element B: UM Timeliness Report

The organization monitors and submits a report for timeliness of:

1. UM decision making.
2. Notification of UM decisions.

Summary of Changes

- No changes to this element.

Scoring	100%	80%	50%	20%	0%
	The organization meets 2 factors	No scoring option	The organization meets 1 factor	No scoring option	The organization meets 0 factors

Data source Reports

Scope of review NCQA reviews the organization's timeliness reports.

Look-back period *For Initial Surveys:* 6 months.
For Renewal Surveys: 12 months.

Explanation This element applies to all UM determinations resulting from medical necessity review, whether they are approvals or denials.

Factors 1, 2

The organization monitors the timeliness of decision making and notification for all requests and, using at least six months of data, calculates the percentage of decisions that adhere to time frames specified in Element A. 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.

Approval decisions must adhere to the timeliness requirements in UM 5 and must be included in factor 1.

Excluded from the timeliness report

The organization excludes:

- Decisions and notifications for nonemergency transportation approvals.
- Approval notifications for factor 2.

Exceptions

None.

Examples

Timeliness reports

Factor 1: Timeliness of UM decision making—Commercial product line

	Urgent Concurrent	Urgent Preservice	Nonurgent Preservice	Postservice
Numerator¹	350	560	875	689
Denominator²	400	575	880	689
Rate	87.5%	97.4%	99.4%	100%

Factor 2: Timeliness of notification of UM decisions—Commercial product line

	Urgent Concurrent	Urgent Preservice	Nonurgent Preservice	Postservice
Numerator¹	350	560	875	689
Denominator²	400	575	880	689
Rate	87.5%	97.4%	99.4%	100%

¹Numerator: The number of cases meeting the decision time frame.

²Denominator: The total number of 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's credentialing policies and procedures specify:

1. The types of practitioners to credential and recredential.
2. The verification sources used.
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, certification and specialty.

Summary of Changes

Policy Change

- Revised the scoring requirement for the 80% and 50% scoring options.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 11 factors	The organization meets 8-10 factors	The organization meets 5-8-7 factors	The organization meets 3-4 factors	The organization meets 0-2 factors

Data source Documented process

Scope of review	NCQA reviews the organization's policies and procedures in effect throughout the look-back period.
Look-back period	<i>For Initial Surveys:</i> 6 months. <i>For Renewal Surveys:</i> 24 months.
Explanation	THIS IS A CORE ELEMENT. The organization must meet this requirement even if it does not have any clients or serve as a delegate. 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.
- 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 members can select as primary care practitioners.
- Practitioners provide care to members under the organization's medical benefits.

The listed criteria apply to practitioners within 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 the types of practitioners:

- Psychiatrists and other physicians.
- Addiction medicine specialists.
- Doctoral or master's-level psychologists who are state certified or licensed.
- Master's-level clinical social workers who are state certified or licensed.
- Master's-level clinical nurse specialists or psychiatric nurse practitioners who are nationally or state certified or licensed.
- Other behavioral healthcare specialists who are licensed, certified or registered by the state to practice independently.

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 decisions.
 - 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 the 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’s or 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

Factor 11 is NA if the organization serves as a delegate but is not responsible for publishing member materials.

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 date for all verifications, with a statement confirming that the signatory verified all credentials on that date, and which includes for each verification:
 - The source used.
 - The report date, if applicable.

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 unless the practitioner is physically impaired.

If the checklist does not include the requirements listed above, appropriate credentialing information must be included.

If the verification is 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. The individual who verified the credentials must also sign or initial the verification.

Use of web crawlers. The organization may use web crawlers to verify credentialing information from approved sources. 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 in a treatment setting (e.g., board-certified consultants).

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 requiring 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 practices in selecting practitioners.
- Annual audits of practitioner complaints for evidence of alleged discrimination.

Automated credentialing systems

- Adobe Sign.
- DocuSign.

RR 2: Policies and Procedures for Complaints and Appeals

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 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 80%, 50% and 20% scoring options.

	100%	80%	50%	20%	0%
Scoring	The organization meets all 5 factors	The organization meets 3-4 factors	The organization meets 2-3 factors	The organization meets 1-2 factor	The organization meets 0 factors

Data source Documented process

Scope of review NCQA reviews the organization's policies and procedures.

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

Explanation **THIS IS A CORE ELEMENT.** The organization must meet this requirement even if it does not have any clients or serve as a delegate.

This element 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 to overturn a decision.

Complaints resolved during the first contact must be categorized as complaints and included in the analysis.

Factor 1: Documentation

No additional explanation required.

Factor 2: Investigation

The organization researches and documents issues relevant to the complaint.

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

Factor 3: Notification of resolution and appeal rights

Members have the right to appeal an adverse decision. If the organization makes an adverse decision 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.

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 that 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 80%, 50% and 20% scoring options.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 5 factors	The organization meets 3-4 factors	The organization meets 2-3 factors	The organization meets 1-2 factor	The organization meets 0 factors

Data source Documented process

Scope of review NCQA reviews the organization's policies and procedures.

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

Explanation **THIS IS A CORE ELEMENT.** The organization must meet this requirement even if it does not have any clients or serve as a delegate.

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

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

Factor 1: Documentation

No additional explanation required.

Factor 2: Investigation

The organization researches and documents issues relevant to the appeal.

Factor 3: Notification of resolution and appeal rights

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

Factor 4: Timeliness

The organization 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.

Exceptions

None.

Examples

Appeals of decision 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 nonpayment 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 is 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 written in English into a member's preferred language.
- Member notification documents that are available in languages other than English.
- Language-line interpretation services for registering oral appeals.

RR 3: Subscriber Information

The organization provides all subscribers with the information necessary to understand benefit coverage and obtain care.

Intent

The organization informs subscribers about benefits and access to behavioral healthcare services.

Element A: Subscriber Information

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

1. Benefits and services included in, and excluded from, coverage.
2. Copayments and other charges for which subscribers are responsible.
3. Benefit restrictions that apply to services obtained outside the organization's system or service area.
4. How to obtain language assistance.
5. How to submit a claim for covered services, if applicable.
6. How to obtain information about practitioners who participate in the organization.
7. How to obtain inpatient and outpatient services, partial hospitalizations and other behavioral healthcare services.
8. How to obtain subspecialty care.
9. How to obtain care after normal business hours.
10. How to obtain emergency care, including the organization's policy on when to directly access emergency care or use 911 services.
11. How to obtain care and coverage when subscribers are out of the organization's service area.
12. How to submit a complaint.
13. How to appeal a decision that adversely affects coverage, benefits or a subscriber's relationship with the organization.
14. Availability of independent, external review of internal UM final determinations.

Summary of Changes

Clarification

- Divided Element A into two elements.

Scoring

100%	80%	50%	20%	0%
The organization meets 13-14 factors	The organization meets 12 factors	The organization meets 11 factors	The organization meets 9-10 factors	The organization meets 0-8 factors

Data source Reports, Materials

Scope of review	<p>NCQA reviews this element for each product line brought forward for Accreditation. NCQA reviews evidence that the organization distributed the information to subscribers.</p> <p><i>For Initial <u>and Renewal</u> Surveys:</i> NCQA reviews:</p> <ul style="list-style-type: none"> • The organization's subscriber information that is in place throughout the look-back period. most recent distribution of information to subscribers. • Evidence that the organization distributed information to subscribers. <p><i>For Renewal Surveys:</i> NCQA reviews:</p> <ul style="list-style-type: none"> • The most recent distribution of information to subscribers for all factors. • The previous year's distribution of information to subscribers for factors 1–13. • Evidence that the organization distributed the information to subscribers.
Look-back period	<p><i>For Initial Surveys:</i> At least once during the prior year.</p> <p><i>For Renewal Surveys:</i> At least once during the prior year for factor 14; 24 months for all other factors.</p>
Explanation	<p>This element may not be delegated.</p> <p>NCQA does not accept or review materials in draft form or that have not been distributed.</p> <p>Information about subscriber benefits and services can be accessed easily and is written in user-friendly language.</p> <p>Distribution of subscriber information</p> <p>The organization distributes information to subscribers by mail, fax or email.</p> <p>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.</p> <p>Factor 1: Benefits and services</p> <p>The written subscriber information <u>Information distributed to subscribers</u> 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 materials state that members have the opportunity to request information on excluded services or procedures and that the organization maintains internal policies or criteria for these services or procedures.</p> <p>Factors 2, 3</p> <p>No additional explanation required.</p> <p>Factor 4: Language assistance</p> <p>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.</p> <p>Use of contracted translation services is not considered delegation.</p>

Factor 5: Claims for covered services

No additional explanation required.

Factor 6: Information about practitioners

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

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

Factor 7: Inpatient and outpatient services

No additional explanation required.

Factor 8: Subspecialty care

The organization tells subscribers if use of certain network specialists is restricted.

Factors 9, 10: After-hours and emergent care

No additional explanation required.

Factor 11: 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 12: Submitting a complaint

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

Factor 13: 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 14: External review rights

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

Exceptions

This element is NA if:

- The organization has NCQA-Accredited health plan business, indirect purchasers or nonemployer business brought forward for Accreditation.
- The organization presents documentation that all clients for the line of business being brought forward for Accreditation explicitly prohibit communication with members.

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

Factor 14 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.

Examples **Factors 1–14: Sources of information for subscribers**

- Subscriber handbook.
- Practitioner and provider directory.
- Benefit 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.

Scoring	<u>100%</u>	<u>80%</u>	<u>50%</u>	<u>20%</u>	<u>0%</u>
	<u>The organization meets 2 factors</u>	<u>No scoring option.</u>	<u>No scoring option</u>	<u>No scoring option.</u>	<u>The organization meets 0-1 factors</u>

Data source Reports

Scope of review Product line

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

Documentation

For Initial 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 Initial 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.

Examples None.